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COMMUNICATION AND COMMUNION IN SOME EARLY MODES OF BECOMING

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"We live," wrote Saint-Exupery, "not on things, but on the meaning of things." And the meaning of things, we might wish to add, is inextricably bound to the range and depth of communion which those things provide. The artist by his mastery and touch opens the commonplace for infinite magnitude, while the pedant slams the door to vistas beyond with a few stultifying platitudes. Communication which is not at the same time communion fails at the point where it is distinguishable as a discrete human activity. Communication is an openness to our depths when it is a living two-way exchange between the individual and the springs of his being and becoming. Apart from such renewing nourishment, man suffers alone and separate—and every other voice is either an insignificant rattling on the roof or the sound of alien claims which can never be met.

In using the word "communication" I suggest that we keep in mind the distinctions between verbal and non-verbal and between conscious and unconscious communication. These distinctions become significant when we bear in mind that, whereas the adult employs all four modes much of

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the time, the very young child is restricted to non-verbal and, in large part, to unconscious communication.

The relation of consciousness to self-consciousness has plagued psychology since the days of William James. The two states are not necessarily identical. Even so, the complexities of their relation are immediately evident to any adult caught momentarily in the embarrassment of "selective inattention." We say that our mind had been "wandering." When it comes to the nature and origin, the subject which perceives itself in consciousness, the intricacies are multiplied. In the earlier Freudian view, the ego was regarded as a "precipitate" which resulted from the interaction between the id and the superego. It emerges sometime after the second year as a referee in the struggle between these opposing forces. While retaining this phenomenological character of the ego, later psychoanalysis has been forced to take into account the fact that some kind of growing center of awareness is present in the infant from soon after birth. There is a tendency now to see this predecessor to the ego as a more or less centered functioning of an innate biological tendency which emerges in the process of organization, regulation, and adaptation to the environment. The relation between consciousness and self-consciousness in this development is still an open question in child development.

In his famous observations concerning the smiling response in infants, Rene Spitz noted that a new kind of visual communication between mother and child develops between the tenth and the twelfth week.[1] At this time the child acquires the capacity to recognize and to respond to the human face. The interesting point here is that the child responds indiscriminately to strangers as well as to mother. But toward the end of the seventh month the infant "recognizes" the difference between his mother and an outsider. Does not this phenomenon represent progress toward the centering of action in an ego which is conscious of itself?

In a recent article on "Sleep, Time and the Early Ego," Gifford has studied the process by which the infant tends to adapt to the sleep and wakefulness pattern corresponding to the night and day habits of adults.[2] The author holds that this adaptation stems from the mother's responsiveness "communicated by her periodic absences or variations . . . which in turn are influenced by her own adaptation to the 24-hour cycle of everyday life." The significant point in this study is its evidence of an even earlier emergence of the primitive ego than that reflected by the smiling response.

If we ask the question, "How soon is communication possible between mother and child?" we are forced to conclude that this primal ego, like its counterpart in later life, is curiously related to the undergirding communion provided from beyond the ego. In his book *No and Yes* on the genesis of

[1]Rene Spitz, "Relevancy of Direct Infant Observation," *In The Psychoanalytic Study of the Child,* Vol. 5, pp. 66-73, New York, International Universities Press.
[2]Sanford Gifford, "Sleep, Time and the Early Ego," *Journal of the American Psychoanalytic Association,* Vol. VIII, No. 1, Jan., 1960, pp. 5-42.

human communication, Rene Spitz builds upon Freud's view that the original helplessness of the child is both the prototype of all anxiety and the spur which drives man toward ameliorative actions. Spitz points out that, although the cry of the infant in the state of helplessness is only a discharge phenomenon, it is interpreted by the mother as an appeal for help which she appropriately supplies. Here, it would seem, we encounter the primary mode for communication at all levels of human experience. Wherever one human being would reach another isolated by distance, guilt, or incapacity, the preliminary act of empathic identification is necessary. Someone—a mother or a helper or a priest or a friend—must take the first step of bridging the abyss of separation and of understanding a distress signal as a cry for help. The words of Irenaeus suggest an analogy with the work of Christ at this point: "He [i.e., Christ] became as we are in order to make us as He is."

The primary mode of communication seems also to suggest that some kind of centered response is present in the infant from the beginning. Certainly it is something less than conscious ego functioning, but it is, to use Plato's words, a locus of becoming. So far we have avoided the use of the word "self." The term "ego" is preferred by the psychoanalysts; and even when they do employ the word "self" as in the case of Harry Stack Sullivan ("Self-dynamism") it refers to a process rather than a self-conscious integrity. But as we have seen, a degree of agency (if only for response) is present in the human organism from soon after birth. It is nurtured by empathic and non-verbal communication with the mother. Within that love it is capable of adaptation to human expectation and, by the twelfth week,[3] to postpone satisfactions in the confidence established by the mother. The twelfth week, according to Willie Hoffer,[4] also marks the period when the hand and mouth are brought into purposeful relation to each other. This voluntary act on the part of the infant to gratify his own instinctual needs is described by Hoffer as "the first achievement of the primitive ego" and a means of establishing "the primitive sense of self."

Most child psychologists would agree that both self-consciousness and a measure of self-identity are possible after the second year. This social self coincides with the acquisition of language skills and the maturation of physical and perceptual facilities. In the light of the ego processes which are in evidence before the second year, however, it does not follow that a locus of identity has been absent from birth. Perhaps we need to think of this receptacle of human becomings as both an integer at every level and as a participant in the greater wholes toward which it tends. We have here, it would seem, the other side of the communication model. In responding to the empathic action of another, the primitive ego achieves a unity which anticipates the larger wholes which it is to become. These two sides of the communication model, i.e., the initiating empathic estab-

[3]According to Spitz.
[4]Willie Hoffer, "Mouth, Hand and Ego-Integration," *The Psychoanalytic Study of the Child,* Vols. ¾, pp. 59-56, International Universities Press, 1949.

lishment of undergirding communion and the gathered integrity of the self (a literal creation out of nothing) in the act of responding, sound strangely like echoes of creation and redemption to our ears.

Communication always requires a mode of participation. One might say that it needs a conductor. Human communication does not occur in a vacuum. Here it is vitally important that means and goals, communication and its mode remain in close contact. "It is genuine communication," writes Emil Brunner, "which remains bound to the act of communication." Biblical religion and liturgical life are built upon this foundation. I would propose the thesis that human becoming and identity are also founded upon the close association of communication and its relevant participatory mode. Specifically I suggest that such basic communication as perception, feeling, and evaluation is shaped by and, in turn, shapes the ego as it acquires such basic modalities as language, identity, and the capacity for play. The remainder of this paper will consist of an examination of this thesis.

In accordance with our thesis we should begin not with such primary acquisitions as perception, feeling, and evaluation as if they were abstracted functions, but with the communion (or the total environment) and its symbolic processes within which these acts of communication are possible. Perception, feeling, and evaluation are always shaped by their prior wholes. They are differentiations within a gestalt. Another way of saying this is to say that what is communicated is dictated in large measure by the culture within which communication takes place. It is said that some jungle people of South America, distinguished for their use of rare detail in Rorschach tests, have acquired their capacity as a function of their need to observe their surroundings in the struggle for survival. Again the "overuse" of space responses by Samoans in the same test reflects "simply the special cultural value attached to the color white."[5] It follows that the specific *Mitwelt* in which we live—its attitudes toward child rearing, its acceptance or rejection of the body, its characteristic rituals and gestures—not only shapes the values which we perceive but also selects in some measure *what* we perceive. As a chaplain on Okinawa, I was always surprised in the nonchalance with which the Okinawan children approached medical inoculations. Apparently our perception of pain is subject to strong social selection.

The fact that cultural forms of communication exist at all depends upon the unique capacity of the human being to translate his experience into symbolic processes. Ernst Cassirer in *An Essay on Man* suggests that this is, indeed, the uniqueness of man. Above all he is an *animal symbolicum*. Between the receptor and the effector systems, Cassirer holds, there is a third system, the symbolic, which translates raw experience into meaningful reality available for our participation. In the light of this inner creativity, this capacity for making and using symbols, it would seem to follow con-

[5]Both of these illustrations are taken from *Culture, Psychiatry and Human Values*, by Marvin K. Opler, Springfield, Ill., Charles Thomas, 1956.

clusively both that (1) man may never be fully understood as a passive recipient of actions (but also as an initiator of actions) and (2) that his primary disturbances, while not exclusive of biology, are in the area of his symbols and their communication.

We are saying that, although the symbolic processes which are the givens in any culture operate by way of coloring and shaping basic perception, these same symbols are also reshaped by the irreducible creativity of man. Indeed, one might go further by saying that man is not only an *animal symbolicum* but also one who is constantly reshaping his symbols in terms of their relevance to his concrete experience of ultimate or vital concern. An experience in clinical pastoral training is, perhaps, relevant here. Recently a student in training complained that a patient who had apparently expressed fear of death during a brief pastoral call "ran away from the issue" when the student by extra effort arranged to see him for a longer period. "But what *did* he talk about," the student was asked. "Oh, he went into a tirade against a sister who always got things fouled up," the trainee replied, "and about a mother who never took anything calmly, and a father who never seemed to care!" The words were hardly out of his mouth when the student added, "But maybe he was spelling out the hopelessness of his own life which is worse than the fear of death which I had expected."

Paul Tillich has said that "the substance of culture is religion and the form of religion is culture."[6] This definition makes it possible to view religion as a universal discrete function which is not confined to ecclesiastical institutions. Religion is evidenced not necessarily in what men say but in what they *do* with their communication. From early childhood the symbolic process becomes the bearer of religious meaning. Here knowing and doing, communication and participation, are intimately related. A clue to the initiation of this process is provided in the primary model of communication and in Erikson's[7] additions to the Freudian theory of psychosexual development. You may remember that Erikson added an evaluative alternative as a means of judging the outcome of each developmental period. Hence the alternatives for the oral stage are trust or mistrust. For the anal period it is autonomy or shame and doubt. The genital development issues in a struggle between self-initiative or guilt. I have suggested that, in terms of the *actional response* necessary for being and becoming at each stage, the Freudian orientations could be translated into *receiving, giving,* and *relating.* Being and becoming for the infant requires one thing: a receiving. A little later, as he gathers momentum within the social whole, the child is required to give as well as to receive. Even later, with the awakening of sexual uniqueness, one begins to learn that he becomes himself by means of intimate and personal relationship. Each means of becoming is incorporated *within,* rather

[6]Paul Tillich, *The Interpretation of History.*
[7]Erik Erikson, *Childhood and Society,* New York, W. W. Norton, 1950. See Chapter VII, "Eight Stages of Man."

than replaced by, its subsequent modes. Now if the self is an integer at every level as well as a participant in the wholes toward which it tends, it seems evident to me that the process which we have been describing is in fact stages in man's journey toward his ultimate identity under God. In this light I would prefer to define religion as man's numinous response to gift in his depths—gift from a source which is wholly other than himself and yet strangely kin to himself. Remembering the primary mode of communication, could we not give assent to Pestalozzi's superb analogy, i.e., that God is our nearest relative! The practice of religion in this view then becomes the celebration of gift giving.

The human capacity for the employment of symbol provides the opportunity to participate in conceptual reality as well as in religious truth. Indeed, it seems to me that one of the most serious problems of religious life is that of holding conceptual theology in close proximity to religious practice. They belong in creative tension. Because both are transcendent products of the symbolic process they easily become isolated from living reality. Creeds as well as rituals have a way of decaying when they become *mere* symbols. Here the empirical emphasis upon the biological rootage of human intelligence is both corrective and significant. Is not the natural origin of instrumentality in human development *also* the source of man's capacity to develop and to employ sacrament? The very young child hardly recognizes his own hand. But as time goes on the hand with fingers and thumb alike become more and more interesting to him. Finally, somewhere around the third month the hand takes the form of a definite object for the child and, now, with fingers and thumb in juxtaposition he is able to hold, shape, and to manipulate other objects. Here, apparently, is the origin of technology. Is it not also the way sacraments are shaped? Every sacrament is also an instrument both in origin and in functioning.

The strategic function of the symbolic system between the registering and intentional capacities of the human animal results not only in his ability to use discursive (or conceptual) and representational reason, but also to employ all of them in the centered act of communication. Let us conclude by looking at this relation briefly, *first* in terms of perception, feeling, and evaluation and *then* in language, identity, and play.

1. Perception is a continuing reminder that our knowing is dependent upon our bodies. Piaget, who perhaps more than any other living human has spent his life observing children, holds that intelligence is rooted in biology. "Verbal and cogitative intelligence," he writes, "is based on practical or sensory motor intelligence which in turn depends on acquired and recombined habits and association . . ." It is interesting, however, that whether it be sucking and vision, phonation and hearing, or any other perceptual source, the observer is faced with the fact that primal raw experience does not give rise to perception until its random-like quality is given meaning either by another who sees this activity as a quest for satis-

faction and acts accordingly or by the maturation of corollary functions.[8] Piaget says that the organism must apprehend any external data within the functions of coherence. In this sense it seems to be quite literally true that one must believe in order to know—or perhaps more accurately one must believe through another in order to know.

2. Feeling represents the difference between the spoken word and the written word. We have noted earlier that the very young child is entirely dependent upon non-verbal empathic communication. If the eye is the organ of perception in general, certainly the ear is the organ for nuances of feeling. Indeed, Harry Stack Sullivan used to say that the main clues to meaning are via the ears—even in adults. When we recall that it is not until about the seventh month that the child can distinguish between mother and stranger, we get some notion of the crucial importance of feeling and empathy during this early period. The child is without the comforting sense of time and space. Even hope—the privilege of adult transcendence—and the alleviation of time are denied him. Without these familiar tests for reality, the adult could not long retain his sanity. In addition, the child is suspended in and subject to parental moods which are not frequently mindful of their crucial importance. Surely here Lewis Sherrill's words ring with an imperative: "The emotional life of the individual as infant and child determines the kind of religion which he can respond to and make his own."[9] One might even go further by adding that the feeling tones provided especially during the first six months of life are highly significant for the child's enduring attitudes toward himself (and thus toward others). Freud recognized this period as one of "primary narcissism." Another word which describes the same condition is "idolatry." Certainly many observers believe that it is here that the self image receives its initial shaping whether of numinous omnipotence or of anxious self-rejection. It is also here that the problem of guilt (around the child's ambivalent attitude toward the mother) begins to appear. And here again it is the mother who, by her genuine contrition for failing to satisfy the child on all occasions, reaches into his isolation by guilt and restores him to communion.

3. Evaluation is certainly present from birth, largely derived from parental attitudes. As a goal, however, it is a constant reminder that the purpose of child rearing is the gradual and appropriate assumption of evaluation within the person. Sprott, in writing about *Human Groups,* notes that "standards have two aspects; they are frameworks of expectation and measures of esteem." The disturbed child is one whose framework of expectation has affected negatively his own measures of esteem. In this connection Erikson has said that Luther was both psychologically and ideologically right when he said in theological terms "that the infant *has* faith if

[8]For instance, according to Piaget, perception of light is present from birth, but in order for it to have meaning (i.e., be a perception of an object) other visual schemata must develop.
[9]Lewis J. Sherrill, *The Struggle of the Soul,* p. 40.

his community *means* his baptism." The growing capacity of the child to take upon himself the responsibility for evaluation and choice remains as one of the miracles of human community. The freedom of the individual, its goal and justification, is as Albert Outler has written, "The mode by which he [i.e., man] responds to the infinite."

When we turn to such acquisitions as language, identity, and play we are struck by the fact that the symbolic process has already fashioned the tools which the growing freedom of the ego is now able to use.

Malinowski holds that the learning of language consists in the development of a system of conditioned reflexes which at the same time become conditioned stimuli. Language is an instrument which is forged in the fundamental social climate of man. George Mead said that language is "verbal gesture." It is intimately related to the emergence of the self which is called out through gesture, response, and resultant action. For the child, to be sure, there remains an intimate relation between word and action. Language, like other aspects of culture, is an instrumental reality. It comes into existence in order to satisfy specific needs. It extends the range of the individual's effectiveness as well as his power of action. Above all, it offers the promise of communication. "Man's capacity for speech," writes Emil Brunner, "is intended by the Creator as receptivity for His Word." Man is *imago verbi divini.* His deepest knowledge is translated by the Word of God into knowledge for action.

Self-identity is profoundly related to the acquisition of language and, as we have seen, to the quality of communication. From the earliest time the emergent center of the person—his selfhood—is a gift which comes in response to prior gifts. The self, as Hume showed, is not a substance but a relationship. It is a linkage of past and future (by anticipation) in this moment of deciding and acting. Hence becoming, in a sense, involves acquiring a memory—a history which is perceived, felt, and evaluated. The dramatic moment in any psychotherapy is the breakthrough signalling the return of memory. And memory in man is always more than a mere recollection of the past. It is *anamnesis* beyond *amnesia.* It is history—and history is always event plus meaning. Cassirer says that memory in man "is not simply a repetition, but rather a rebirth of the past; it implies a creative and constructive process."

"To be a self," writes H. Richard Niebuhr, "is to have a God; to have a God is to have a history, that is, events connected in a meaningful pattern; to have one God is to have one history. God and the history of selves in community belong together in inseparable union."[10] Personal identity is both the fruit and the means of human becoming. As John MacMurry has said, "In the strict sense of the term only a person can 'act' or in the proper sense 'do' anything."

[10]H. Richard Niebuhr, *The Meaning of Revelation,* p. 80.

Play is the child's way of dealing with experience by creating model situations in which he is able to master reality by experiment and planning. It follows that the child, like the adult, reveals himself in play. It is here that the child in relation to all the new challenges of existence is continually recapitulating his whole history through invention and personification. It is here that his identity and his struggle for uniqueness are reconfirmed again and again. Recently, a child in therapy at St. Luke's Hospital played and replayed with family figures which he identified as "Daddy, Mamma and the twins," always leaving himself out. Finally there came the day when he could identify and include himself in the family constellation.

Conclusion

I wonder if one helpful way of looking at liturgy is not to regard it as an activity on our level which is equivalent to the child at play. The word *liturgy* is derived from an expression which originally referred to a public duty or service of any kind. It is, indeed, the public manifestation of the inner meaning of a people's life. It is in play that man brings together the most profound unity of worship and work. Dance and song are woven into the pattern of adoration. Why? Because, as Bergson held, action cuts the knot of "absurdity" which reason tends to attach to anything beyond itself. Play is action and commitment like swimming beyond theories of specific gravity, etc. The shape of the world we live in is derived not primarily from concepts, but from action. It is lived in and through our bodies, our choices, our gestures, and our liturgies—by color, shape, and sound. Each man's existence is a drama which carries onto the stage of action the living embodiment of all that he is or believes.

The eucharistic liturgy, because it carries prayer into an act, "is and must be to some extent the expression of a conception of human life as a whole."[11] Liturgy in this broader sense reveals the meaning of the child's life in and through the communication and communion which his modes of becoming provide. The child provides his own liturgy through his responses in play, and it is our task to give attention to his communication.

[11]Dom G. Dix, *The Shape of the Liturgy,* Westminster Press—Darle Press, p. xviii.

THE PROBLEM OF ANGER: A MESSAGE FOR THE CHURCH

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One of the duties I perform as a mental hospital chaplain is to make pastoral calls on the newly admitted patients who come to our hospital. From the admitting office I receive a card which gives me pertinent information about the patient—age, sex, church affiliation, and, of vital importance, the reasons for his hospitalization by the courts.

Over the years I have noticed that the emotional factor of anger is one of the main reasons given for the commitment of a large proportion of our patients. Here are some of the statements I have read on the admitting cards: "John became unruly, destroying furniture in the home," "Mary became very assaultive toward members of the family," "Patient claims that God told him to kill his wife," "Joe has become more sullen and withdrawn, recently purchased a gun and members of the family are frightened for their safety."

Then there is another large body of patients in our hospital who show no outward signs of anger but who our psychiatrists tell us are equally as hostile as those patients who openly manifest their anger through their illness. These are the depressed persons who seem to have no interest in life, are unable to sleep or eat, frequently care little whether they live or die, and in many cases have attempted to take their own lives. Formerly these patients were treated with electric shock therapy, but presently they are recognized as being inwardly angry and the type of treatment is designed to help them express or externalize their anger. For instance, they may be given unpleasant tasks to perform and thus be given opportunity to discharge their feelings of anger.

From experience with many patients I have come to see what a serious problem anger really is in the lives of people in our culture. Even more important has been my appreciation of how deceptive is the problem of anger, and how hard it is for people to face and deal with anger. I have also come to realize that anger and love, and anger and creativeness, are all closely bound up with each other; that many people who try to be loving and creative experience failure because of the repressed anger which keeps them from being able truly to love and be creative. The pathetic

aspect of this whole problem is that because of man's inability to deal with anger he is driven into all types of illnesses and suffering.

With the realization of the major importance of anger in our lives, I wish in this paper to set forth some thoughts on the subject. In this discussion I shall consider first the origin of anger; second, how individuals seek to deal with anger; and then, third, I would like to consider what kind of a message there is for the church in this entire problem.

The Origin of Anger

Certainly there are few, if any, psychologically oriented people who would believe that anger is an aspect of the nature of the newborn infant. I, personally, believe that the infant has the capacity for anger, but I could never hold to the view that anger is a part of the nature of man. The fact is that anger is an element foreign to man's nature. Because this is true man is always disturbed when he has angry impulses and can never have any degree of contentment in his being until he has been able to work through these impulses.

The first relationship of the newborn infant is that of normal give and take between him and his mother, with no "thought" in the infant's mind of "the mother's sacrifice" or of a "burdensome obligation" on his part.[1] This is an undisturbed, ideal relation as long as the basic needs of the infant are met by the mother. But when the needs of the infant are not met, and if there are persistent frustrations in the fulfillment of its needs, the normal and inevitable feelings are those of rage.

Although anger later originates from many sources and from all the frustrating experiences of life, the basic patterns toward anger are developed in these early experiences of infancy and childhood, when the image of the self is being formed in the individual. The kind of person which will develop is determined by the pleasantness or unpleasantness of these early experiences.[2]

The origin of anger in the earlier life experience of the infant is best described in these words:

> The human being whose needs are not met when he comes into the world, who is an unwelcome addition to the family, who is neglected and who lives in an environment that is indifferent and cold toward him will develop hostility, resentment, hate, pessimism—all of which makes it very difficult for him to function.[3]

We are indebted to psychoanalytic studies of the infant and child for having described two well-defined periods of growth in their early development. There are other periods of growth, but here we shall be concerned

[1]Ian D. Suttie: *The Origins of Love and Hate;* The Julian Press, New York, 1952, p. 38.
[2]O. Spurgeon English and Gerald H. J. Pearson: *Emotional Problems of Living,* W. W. Norton, New York, 1945, p. 11.
[3]*Ibid.,* pp. 11, 12.

with the first two stages which, according to psychoanalytic thought, are of importance in early personality development. It is in these first two periods that the patterns toward anger are set.

The first period is spoken of as the oral period. This is the time of breast- or bottle-feeding. In its earliest stages this period is one of complete helplessness and dependency. It goes without saying that no individual can go through this period of life, or any other period, without undergoing frustrations. And, without frustrations, a person cannot develop a personality with any degree of strength. Our concern here is not with the ordinary, necessary frustrations that lead to development, but with "sudden large doses of the necessary frustrations or to unnecessary and unusual ones"[4] which create deep and abiding angers and a deep sense of separation between the person and the world about him.

The frustrating experiences which the infant undergoes in the oral period are numerous, but we shall mention only a few of those unnecessary frustrations and angers that create a feeling of separation and aloneness within the infant. One of these would be the weaning of the infant before he is ready to be weaned and by means which are unpleasant to him.[5] Another would be unhappiness of the mother during the feeding of the child or any unhappiness in the home during the nursing period—circumstances which the child senses and which interfere with his feeling of well-being.[6] Frustration may also be experienced through problems of nursing.[7]

The second major period of early personality development differentiated by psychoanalysts is the anal period, more commonly known as the period of toilet training. While some demands are placed upon the child in the oral period, they are quite incomparable to those which he meets in the anal period. Reality now begins to be more focused for him as being something more than himself, something external to himself. He begins to emerge as a person who is expected to take care of himself to some degree. He has begun to walk, to talk, to reach for things, and in general to do things for himself. It is of this period that Hendrick writes:

> . . . his anus supplants the mouth as the chief source of sensual pleasure. Its full enjoyment, however, is soon much restricted by toilet training, and his resentment of this frustration of his pleasure is expressed in phantasies in which defecation represents defiant aggression and destruction of the hated one.[8]

Anger probably originates more often in the anal period than in any other period in the life of the child, for it is in this period that the greatest demands are made upon him to grow up and to give up instinctual gratifications. Since up to this time he has been largely dependent and relatively

[4] *Ibid.*, p. 32.
[5] *Ibid.*, p. 39.
[6] *Ibid.*, p. 35.
[7] *Ibid.*, p. 33.
[8] Ives Hendrick: *Facts and Theories of Psychoanalysis,* Alfred A. Knopf, New York, 1958, p. 51.

few demands have been made of him, he finds it most difficult to accept these greater demands now placed upon him by the adult world. The fact that the mother often finds his peculiar kind of pleasures hard to accept and understand makes this period even more anxiety-producing for the child in our culture.

To sum up, let us state some of the reasons for the origin of anger in the period of toilet training. One would be the initiation of training before the child is ready for it. Another is the inability of the mother to understand and tolerate the right of the child to erotic needs of play. Still another is the tendency of the mother to create in the child a feeling of shame and disgust in relation to the evacuatory process, which to the child is part of his instinctual craving.

Whether one looks at these early functions in terms of the more sensual aspects or purely in terms of the interpersonal relations of the child and his parental figures, the fact remains that what is important is that patterns of personality are being formed. These personality patterns will determine whether the child will live in close relationship with others or be rebellious and defiant—an angry individual.

How Persons Come to Cope with Anger

Unaccustomed to the feeling of anger, infants and children are frightened by it. It makes them feel alone and separated from those people with whom they have felt close and upon whom they are dependent for their love and for the necessities of human existence. They are afraid that their anger will destroy those very persons upon whom their existence depends, and this fear makes them feel even more alone. Moreover, they are afraid that it will be discovered that they have such feelings and that they will be punished for having them.

Because of these fears, their dependent state, and their need of those individuals toward whom they feel angry, it is natural that infants and children seek to deny their anger, for, if they express it, they may lose what love they are already receiving. Since they must deny their anger, they learn to cope with it through forms of behavior other than the direct expression of their feelings.

We find that individuals express their anger through deep cravings for those things which represent their earliest level of development where they suffered rejection and became angered. For instance, persons who were weaned too early may show an overemphasis on eating or talking in their adult behavior, thus expressing their anger through an excessive interest in activities that are related to the origin of the anger. Others may express their anger more openly in the form of denial of interest in the things which related to their having experienced anger. We shall look now at an example of such behavior.

The patient was an attractive young lady in her early thirties who was

depressed, withdrawn, and untidy in her appearance. During an early office visit a volunteer worker came in and left two cups of ice cream. I handed a cup to my patient and immediately began to eat from my cup. My patient started to eat from her cup, then put it down, picked it up again, hesitating, not knowing whether to eat it or not. It then occurred to me that she had some sort of oral difficulty with food which was reflected in her reactions to the ice cream.

After working with her for several months, I felt that she was improved to the point that she could be transferred to a ward where she would be less confined. Her doctor approved, but feared that she would eventually refuse to eat, as she had in the past, at which times he had had to treat her with electric shock before she would eat again. Again I was struck with the fact that she had oral difficulties.

She was transferred to the open ward and shortly after she requested that I help her get a job in the employees' dining room. Again I noted her interest in an area associated with food. Also, at about this time, she had requested her mother to buy her a meal ticket which would permit her to eat in the employees' dining room. She became very upset when the mother refused to buy the ticket, even though she was financially able to do so. Upon meeting the mother and coming to know her quite well, I felt that the refusal to buy the ticket was indicative of the mother's oral rejection of this patient throughout her life.

I succeeded in getting the young lady employment in the dining room so that she might get her meals there. After she had been there for several weeks the dietitian reported to me that the patient would not eat her regular meals, but instead drank coffee all day long and devoured sweet rolls one after another. At about this time it was also reported to me that she was going to the patients' canteen and purchasing large amounts of candy.

I worked personally with this patient for more than a year, during which time she was for the most part very normal, sociable, and able to take complete care of herself and her needs. But there were times when she was very disturbed. One Sunday afternoon the attendant called and asked me to see her. When she came to the office she was in a very disturbed, distant state. It was quite apparent that she was hearing voices and was not in very close contact with reality. I felt very discouraged and made a desperate attempt to reach her by using the direct analytic technique of Dr. John Rosen, interpreting to her directly what I thought was going on within her unconscious.

I first asked her what the trouble seemed to be. She managed to pull herself together somewhat, with the expression that I just wouldn't understand—certainly she couldn't understand. Then she said that recently she had been able to eat meat at her meals, but that at the noon meal she could not eat meat and had the feeling that her food had kerosene in it. Then

I made my interpretation by saying, "Yes, I understand. When you were a small girl and your mother fed you, you didn't really feel that you were getting food for there was no love with the food your mother gave you." To this she responded by becoming more alert, looking at me with a more normal expression, and saying, "When I was a little girl I was real skinny and my mother gave me Carnation milk." I replied that what she meant was that her mother gave her milk that was really not milk for there was no love. This seemed to relieve her greatly; she relaxed in her chair, breathed more deeply, and said that her mother had recently brought her a bottle of Jergens lotion, which she had dropped and broken, then felt that the lotion had gotten all over her body and into her breasts, which she had previously complained about as being sore.

The treatment of this patient ran well over two years and, though she had her ups and downs, she continued to make progress and never regressed to an extent which made it necessary for her to return to her old ward. Her greatest progress came shortly after her mother died, when she appeared to be a different person, became interested in the other patients and helped them in any way possible. She showed particular interest in one of the young men patients and took more interest in her personal appearance. The last I heard from her was that she had left the hospital, was living with an aunt, and was dating a psychiatrist.

Without a doubt excess frustration had taken place in this patient at the oral level of development and she expressed the anger generated by this frustration by denying the need which was not satisfactorily met, i.e., by the refusal of food, and by a craving for certain foods such as sweets and coffee. The latter I believe was an attempt to satisfy the deep hunger which was intensified through the inner anger over the fact that her early needs were not met. It seems likely that her sudden improvement after the death of her mother came about because, deep within her, there had been the wish for this death, a wish which was caused by her anger toward her mother for having failed to meet her early needs.

Other more widely known behavioral patterns of coping with anger which originate in the oral period are what we often call the passive-dependent personality patterns. Foremost among these patterns are alcoholism and lack of drive or initiative. Anger in persons who use these modes of coping with it is never openly manifested, and it is for this reason that people who have anything to do with these individuals usually get so put out with them. These passive-dependent people have their anger so hidden and so subtly expressed that we do not realize that they are angry and so we, in turn, are angry with them, or feel sorry for them. Their anger is expressed through their passivity, their regression to infantile behavior patterns, and their forcing us to take care of them.

One such person, a young man in his early thirties, was committed to our hospital. He sat most of the time in the day room of the ward just staring out into space, his face frozen, with no expression whatsoever. If

anyone spoke to him he would answer in a negative manner. If he was told to do anything he would do it in a grudging way. Eventually he stayed in bed and refused to feed himself. For more than a month he stayed in bed and would not speak. Daily the nurses and aides had to tube feed him. As they did so he showed no expression, but passively took his food like a baby. His behavior was the ultimate in expressing anger through becoming completely dependent and forcing others to care for him as though he were an infant.

Let us turn now to some of the defenses that are formed as means of coping with anger arising in the anal period of development. Among these defenses are over-niceness, courteousness or extreme politeness, and condescension. It is not too difficult to see how such character traits are derived from experiences which the individual underwent at the time of toilet training.

To a mother's extreme emphasis on the child's being clean, good, and giving up his play and interest in excrement, and a demand that he become toilet trained before he is physiologically ready for such training, the child reacts by having feelings of extreme anger toward the mother. Being afraid of his anger and its possible effects, he denies it and meets the demands made upon him in order to please his mother and keep her love. But in pleasing her, when he feels angry underneath, he loses the spontaneity of his own feeling-self by becoming an extremely good boy and being overly polite and courteous.

The case of a young male psychotic illustrates anger which is defended and dealt with by the individual in the compulsive personality patterns of artificiality, compulsive niceness, and courteousness. This young man was obsessed with the excrement and excretory processes of animals.

I have said that individuals often deal with their anger in an overemphasis of the need which they were denied, the need which caused the anger in the first place. If needs are fulfilled at the time they arise, they will drop out of their own accord or develop naturally and will not assume the importance which they later assume if they are not met or if pressure has been placed on the individual to give up the need. In the case just cited the persistence of the interest in the defecation of animals is undoubtedly related to an early denial of his own anal interests in his early development, and, because of the denial, the need continued with even greater force than it originally had.

In the case of this young man the more normal defenses of extreme niceness and politeness were unable to maintain his personality so that he could function on a neurotic level. Instead, these defenses broke down and he became psychotic. With the original frustrations of early childhood having come out into the open, and with his unconscious feelings being revealed more openly, we see where his extreme feelings of anger actually originated.

Still another way that individuals deal with anger is in that personality pattern in which individuals are exacting and meticulous, and there are no better examples to be found anywhere than in that religious body of men in the New Testament known as the Pharisees. The Pharisees, as the interpreters and keepers of the Judaistic religious laws, followed the law in all of its exactness and tried to see that other people did the same. Excellent examples of the anger which is hidden in such personality traits are to be found in their treatment of Jesus. In their confronting Jesus regarding his failure to follow the law and the failure of his disciples to do the same and in their responsibility in his eventual death, we have some of the most subtle and open expressions of hate. And where will you find a greater expression of murderousness than in the Apostle Paul in his persecution of the early Christians? And Paul, as he stated about himself, was a Pharisee and the son of a Pharisee.[9]

Another behavior pattern which develops in the anal period as a means of attempting to cope with anger is seen in those individuals who do not quite establish those character structures of niceness and exactness but instead become rebellious and openly hostile toward authority. Often we find that these rebellious people try to be good and conform, but then suddenly, and in a most impulsive manner, they will switch and turn against those very things which they tried to conform to.

Dealing with anger through bodily, somatic symptoms is another large area which has come to our attention in recent years through psychosomatic medicine. We have only to read some of the psychosomatic studies and follow the explanations given therein of such illnesses as hypertension and ulcers to realize how great a factor anger is considered in these ailments.

Fear is another method of dealing with anger. An excellent example was the case of a young lady in her late twenties, whose pastor sent her to me for counseling. She feared that she would pass out in church and at football games, and that she would die.

Over a period of some five months of counseling, seeing her once a week, I learned that she did not have a particularly close relationship with her father. Each evening he picked her up after work and drove her home, but he was a very unstable person, moving from one job to another and usually taking jobs that did not offer much security. This placed a burden on the mother, who also worked and who had to carry much of the financial responsibility for the home. For these reasons the daughter was quite put out with her father. Moreover, the father did things which he knew irritated his daughter, such as wrapping her Christmas packages when he knew she wanted to wrap them herself.

This young lady had been engaged and had set the wedding date, but, as it neared, she became so unsure of herself that she had to call the

[9]Acts 23:6.

wedding off. It was following this that her pastor counseled with her and finally decided to send her to see me. I tried to help her to become consciously aware of just how angry she was with her father, but then she felt that she should not have this anger. As she said, "Anger is wrong. It is not Christian." To this I replied that neither is dishonesty Christian, and that she was being dishonest with her feelings by trying to deny her anger. I helped her see that anger is never so bad as when we try to deny it.

After about a year of counseling, she got to the place where she could accept and have some tolerance for her honest angry impulses. Then she moved into a distant state and married. Her problems were not completely solved, but her story points up the significance of anger in its realtion to fear.

There are other methods that people use to attempt to cope with their feelings of anger, but this discussion will suffice to point up some of the major ways.

A Message for the Church

For the insights into the problem of anger in human behavior which we have discussed we are greatly indebted to the psychological sciences, primarily psychoanalysis. In these insights there is a very wonderful message for the church. What is particularly interesting about these insights is the fact that they are not too far removed from the church's redemptive mission to mankind. Actually the message for the church about the emotion of anger is quite supplementary to the mission of the church.

Traditionally stated, the work of the church has been to bring salvation to men who are lost, and our first message to the church is that the lost man is often an angry man. For, we might ask, in what more meaningful sense can we view man as lost than when he is burdened down with anger, which is very inaccessible to him because it is unconscious.

We think of man as lost here when he feels separated in his deeper, abiding relations with his fellow man, with God, and with the world. I have pointed out that the infant has a relationship of oneness with his mother. But once he feels anger because of severe frustrations he begins to grow tense and reacts in part by the tightening up of his organism. He has difficulty in openly expressing his anger but instead feels it inwardly. It is at this point that an individual begins to feel alone, cut off, and lost. He goes on guard, is not so trusting as he originally was, his responses to the world are not free and spontaneous but mechanical and doubtful in nature. Whether the lost person is a psychotic who becomes completely confused with reality, living totally within himself, an individual who is openly rebellious such as a delinquent, or the person who is compulsively exacting or overly nice, the problem is one and the same. It is a matter of man's being cut off from himself and his true feelings—a matter of his being alone and not related. My contention is that the primary reason for this state of being is man's angry feelings.

What better example can we find of a lost person than the demoniac whom we are told about in the New Testament.[10] Here was a man who personified anger or rage. He was described as a man who could not be bound with chains. Not only was he separated within himself because of the rage within him, but he was even further separated from society by having to live within the region of the tombs.

Another message for the church comes from the realization that back of the aloneness of this man there was a wish to return to the original state of oneness which he knew before he experienced anger, and thus experienced his state of separation, but that such a return to oneness is not easy. For, even though man wishes to return to close relationship, the anger within stands as a wall between his separation and the desired oneness—a wall that is usually invisible because man cannot see his anger. Therefore, if he is to be restored to a state of oneness he must first come to grips with this wall, and, since he cannot see his anger and thus cannot deal with it, he is unable to do this.

It is because of this inability of schizophrenics to come to grips with their difficulty that psychiatrists look so pessimistically upon their ability to get well. They are so afraid of their anger, and it is so deceptive to them, that they cannot recognize and deal with it. It is because of this difficulty of man in dealing with his anger that we in the church should consider seriously that a person may want to get well, to be saved, but there is often that element of anger which keeps him from being able to do so. I am convinced that our psychiatrist friends are far more aware of this resistance to getting well, or being saved, than are we in the church.

The most important message for the church in our dealing with angry people is that we must accept them as they are and not insist that they change. We have learned that anger originates in infancy when a child is made to give up a form of behavior which is pleasant to him and to conform to the kind of behavior which adults approve. This demand for change makes the child angry and may cause him to need to persist in the behavior he was pressured into giving up. Moreover, the greater the pressure, the more determined he seems to persist.

Quite often we in the church get vexed with psychiatrists because they seem so unconcerned about persons in their care. It appears to us that the psychiatrist is not interested in doing very much to help the person change his behavior and become a more related human being. A minister friend said to me that he would like to undergo analysis but was afraid that he would end up like a limp rag with no interest or drive in trying to help people with their problems. I think that what he was aware of was the tendency on the part of the psychiatric worker not to be too compulsive in aggressively trying to change human behavior.

[10]Mark 5: 1-15.

Far too often I think that it is true that we wish that others would give up their state of separation and live as we want them to live, in close relation with other human beings. We may be perfectly sincere in our wish, but still, by that very wish, we show that we do not accept the person for himself by respecting and appreciating his need to be alone and be in his state of separation. Frequently we are obsessed by our own need to see him change for us and not for himself. Thus we repeat the same experiences which he originally experienced when he found it necessary to give up needs that were important to him and become what other persons insisted that he become. The psychiatrist realizes the danger of repeating the same behavior which created the anger within him and therefore shows little interest in getting him to change.

Psychiatry works on the principle that it is man's basic nature to be loving and to be good. Man wants to be loving and to be loved, even when he is most alienated from himself and his fellow man. But the kind of love which he wants is a love in which he will be accepted for himself, completely and wholly as he is. It is only when such love is present that the shackles and bonds placed about him by the anger at not having been accepted for himself, and according to his needs, can be loosened and he can join in true fellowship with other human beings. It is evident from this that any change in the angry person must come from within himself, and this fact the psychiatrist recognizes.

What the psychiatrist does, then, is to give a relationship of acceptance. In such a relationship the angry individual will in due time begin to wonder about this person who is interested in him but does not tell him to change. The person who tells him that he should do thus and so he can understand much easier than a person who just accepts him as he is. He can get his defenses up against the former, but he finds it very difficult to deal with the latter.

Complete acceptance of an individual as he is, is probably one of the most difficult tasks that we of the church have to do in aiding persons to regain salvation and a feeling of being in relation with God. The task is made more difficult by the fact that within the individual there exists very serious doubts about our intentions and that he will try again and again to test out the genuineness and sincerity of our acceptance of him. The message for the church concerning this problem is that we must search out our own feelings and motivations for what we envision as salvation for the persons we seek to help, just as in psychotherapy it is important that the therapist undergo a long period of therapy in order to understand his motivations and to be sure that his desire to have the patient change grows not out of his own needs but rather out of the needs of the patient.

The person's need to test our real interest in him, which I mentioned above, is actually an expression of anger toward us, for doubt is one means of expressing anger. If our egos are weak and we are in need of acceptance,

finding it difficult to tolerate anyone who would test our integrity, then the chances are rather good that we are not the kind of individual who can accept the troubled person with the anger which he is expressing. Likewise, if we are motivated by a compulsive need to be helpful, it is not likely that we can be helpful to a person suffering from anger, for it is quite possible that our compulsive need arises from anger just as does the over-niceness of the extremely courteous or exacting person that we pointed out earlier.

Jesus said that he had not come to be ministered unto but to minister, but we might say of ourselves, when we are motivated out of a compulsive need to be helpful, that we come to be ministered unto rather than to minister. It is true that we are more likely to be helpful when we are less helpful, for then we can present to angry persons a soul which is unblemished by feelings of anger. And not only must we be free from anger, but we must be unafraid of it. Knowing a person who is afraid will make the angry person more frightened of his own anger, but knowing someone who is not afraid helps the angry person to lose his fear of his own anger. It seems quite likely that one of the reasons that Jesus was able to help the demoniac was because Jesus was fearless.

We should always keep in mind that where there is anger there is the need for love; there is always the wish to live in a close relation of love and to be restored to the original relation the person knew before he experienced anger. A psychologist friend once said, "Isn't it interesting that when people in psychotherapy express anger and find acceptance in such expressions, these expressions of anger are always followed by warm expressions of love?"

Summing up my thoughts on a message for the church about the problem of anger, I have pointed out that the lost person is often an angry person, who, though lost, still wants love and relationship. He is looking for relations with human beings who can accept him for himself, as he is, without ever demanding that he change. Such acceptance gives the angry person the kind of relationship he longs for and makes him want to change. I have said that if we of the church are secure enough to offer him true acceptance, not pushing ourselves on him more than he is ready or able to take, or pulling ourselves too far away from him, he can then be restored to a feeling of being truly related with the totality of reality. If we can succeed in offering such a relationship, we shall be fulfilling the mission of the church and the redemptive process in its finest meaning.

RELIGIOUS ATTITUDES OF MALE NEUROPSYCHIATRIC PATIENTS: II. COMPARISON OF RESPONSES OF PATIENTS AND NON-PATIENTS

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Although the general area of religious behavior and religious attitudes has received the attention of a number of investigators, only a few empirical studies have been reported in the area of the religious attitudes of the emotionally ill.

Rutledge (9) investigated the concepts of God held by the emotionally upset. This author asserted that bizarre religious ideation in the emotionally ill may be symptomatic of the illness and/or causative. A primitive concept of a cruel, arbitrary, and wrathful God was found frequently, as was a concept suggestive of an erotic relationship which was both escapist and regressive.

Southard (10) reported on the "significance of religion in 177 patients" at Central State Hospital, Lakeland, Kentucky, "as revealed in chaplain interviews with the patients." This author found no significant relationship between denomination, or the fact of church membership, and psychiatric diagnosis. Dr. Southard concludes that "the way in which religious teachings are presented is as significant as the teachings themselves . . . and patients are quite selective in what they will receive from religious teachings." Religion may serve as a precipitating factor in mental illness, and religious teachings and symbolism may be used in the expression of the patient's psychosis. Dr. Southard stressed that some patients "use their religious teachings to good advantage in making satisfactory adjustment and in receiving personal strength to work through their problems." Religious phrases and symbols may supply "the terminology used by a patient during an excited phase of his psychosis; and at a later time religion may be of positive benefit."

Oates (6) reported on extensive analysis of case histories and individual interviews and group contacts with 68 patients from the Kentucky State Hospital. Dr. Oates found that in eleven of these patients character and personality had been warped by religious influence. For 7 patients, religious

This Study was conducted at the Veterans Administration Hospital, Leech Farm Road, Pittsburgh 6, Penna.; and was partially supported by the Research Committee of the Hospital. Conclusions expressed are those of the authors, and do not necessarily reflect the opinion of the Veterans Administration.

experiences had served to precipitate the illness. For 14 patients, religion supplied the ideational content or form of the illness. Finally, in 35 patients, there was no religious concern shown at all. Dr. Oates has drawn from this study, and from other extensive experiences, the material for a recently published book on the subject. (7)

Boisen (2,3,4) has contributed much to the understanding of religious attitudes and ideation in mental illness. A basic assumption underlying one of his studies is that "functional mental illness is the price we have to pay for being human and having the power of choice and the capacity for growth" (3, p. 288). In an extensive study of the case histories of 78 patients, Dr. Boisen found that in those patients in which acute anxiety (as contrasted with an acceptance of defeat) was the characteristic reaction pattern there was a greater likelihood of a favorable outcome to their illness. In 8 of these patients, "mystical identification" was the method of expressing acute anxiety; and among those 8, Dr. Boisen found 2 much improved, 5 improved, and only 1 unimproved. In contrast with this, Boisen found 8 patients in whom "self-deception" was the method of accepting defeat; and among these 8, he found none who was much improved, 5 who were improved, and 3 who were unimproved. Further, Dr. Boisen found that in the 28 patients in which religious concern was accentuated, 14 per cent were much improved, 64 per cent were improved, and 22 per cent were unimproved; whereas, in the 50 patients in whom no religious concern was expressed, 2 per cent were much improved, 42 per cent were improved, and 56 per cent were unimproved (3, p. 292).[1]

In another article, Dr. Boisen (2) discussed the therapeutic significance of anxiety.

Nilsen (5) analyzed biographical material stressing crises experiences in religion. He found evidence of a high correlation between the idea of a "strict" God and a "lowered self-evaluation," with a "subsequent narrowing of life space and proneness to emotional instability and social maladjustment."

The senior author devised the Inventory of Religious Attitudes as a technique quickly to assess the patterns of religious attitudes of a patient in order to facilitate counseling with the patient and with his family. The Inventory was also used to secure information in the setting up of group sessions for the patients. It should be noted at this point that this Inventory was devised to be used only with Protestant patients. The clinical use of this instrument will shortly be described. It was perceived to have research possibilities, as well. In its Revised Form I, the Inventories and clinical reports were analyzed for the most frequently expressed attitudes, feelings, general religious sentiments and problems of 130 patients (8).

In its Revised Form II, the Inventory consisted of 151 statements of religious attitudes and feelings. The following statements will serve to illustrate: "God causes people to suffer"; "God hates people who are wicked"; "The soul is merged in a world of spirits"; "We must believe

[1]Percentages were compiled from Table 3 of that article.

the Bible from cover to cover"; and "After people are baptized, God protects them from all danger." The 151 statements are divided among twelve major areas, namely, God, Prayer, Immortality, Heaven, Jesus Christ, Parents, Failure in Life, Bible, Sunday, Wealth and Poverty, Man, and A Child's Death. Patients responded to this Inventory with a "Yes," "No," or "?," expressing—consecutively—agreement, disagreement, or uncertainty with regard to the religious attitude or feeling expressed by the item. In addition, each section included space for write-in comments.

This Inventory was administered to the newly admitted Protestant patients to the Acute and Intensive Treatment Service of this Hospital. These incoming Protestant patients were seen in a group each week, by the same investigator.[2] Either the Ward Physician or the Supervising Nurse made the decision as to whether or not the patient was in sufficient contact adequately to fill out the Inventory. If a patient—for any reason—could not be included in the group one week, every effort was made to have him included in some subsequent week. Groups ordinarily consisted of from two to five patients. When the patients had assembled in the conference room, the purpose of the Inventory was stated, biographical information was obtained from each patient, and the Inventories were distributed and filled in.

Each completed Inventory was summarized and analyzed for both clinical and research purposes. For its clinical use, a report was written, which sought to detail the patient's pattern of religious attitudes, the conflicts involved, and to recommend the kind of counseling by the Chaplain that would be of most benefit to the patient. A copy of this clinical report was placed on the patient's medical chart, and thus it was available to assist other professional personnel to understand the behavior of the patient, particularly his religious behavior. In the preparation of this report,[3] the patient's write-in comments proved to be most helpful, though not subject to statistical treatment.

For research purposes, we set out to determine the extent to which the Inventory differentiated between neuropsychiatric patients and non-patients. In order to fulfill this purpose, the Inventory was administered to a number of "normals," including hospital personnel, students, service organizations, and men's church groups. The non-patients used the same system of responses to the individual items of the Inventory as did the patients.

Revised Form II of the Inventory was used at this Hospital from November 1956 through July 1958. It was administered to 120 patients on the Acute and Intensive Treatment Ward and to 131 non-patients. None of the latter group exhibited any overt psychiatric symptoms.

Table 1 details the characteristics of the two populations used in this study.

[2]This activity, together with the detailed analysis of the individual Inventories, was largely the responsibility of the junior author.

[3]A Manual for the Administration and Interpretation of the Inventory of Religious Attitudes, Revised Form II, has been prepared. A copy may be obtained upon request from the authors.

TABLE 1

CHARACTERISTICS OF THE TWO ALL-MALE POPULATIONS USED IN THIS STUDY

VARIABLE	ACUTE AND INTENSIVE TREATMENT SERVICE PATIENTS	NON-PATIENTS
N	120	131
Age: Range	20 to 50 years	16 to 50 plus
Median	30.5 years	31 years
Race: White	103	114
Negro	17	17
Education: Elementary	27	6
High school and/or high school graduate	66	91
College and/or college graduate	18	21
College, plus graduate work	1	12
Not given	8	1
Marital Status:		
Single	60	
Married	43	
Divorced, or separated	15	
Not given	2	131
Armed Forces Status:		
Army	72	13
Navy	20	4
Marines	10	3
Air Force	17	3
Coast Guard	1	0
Not given	0	55
Not in Service	0	53

In Table 2, are tabulated the psychiatric diagnoses of the patient population. The "normals" in the study were all non-patients and gave no outward indication of any psychiatric symptoms.

TABLE 2

PSYCHIATRIC DIAGNOSES OF THE ALL-MALE PATIENT POPULATION

DIAGNOSTIC CATEGORY	NUMBER
Schizophrenia: Paranoid	15
Catatonic	6
Hebrephenic	4
Affective Type	1
Mixed	1
Undifferentiated	47
Schizophrenic reaction	1
Schizophrenia—manic depressive	1
Dementia praecox	1
Psychosis (not otherwise differentiated)	12
Psychotic—Depressive Reaction	4
Depressive reaction	1
Psychoneurosis	6
Anxiety reaction	8
Anxiety reaction—chronic alcoholism	2
Personality disorders	1
Epilepsy	1
Chronic brain syndrome	2
Encephalopathy; chronic brain syndrome	1
Total	120

For the purposes of this study, the "Yes," "No," and "?" responses of both the patients and the non-patients to all of the items in the Inventory were tabulated as to frequency. In order that statistical treatment might be given the data, a null hypothesis was set up; to wit, "There are no significant differences between the responses of a neuropsychiatric patient and a non-patient population to the items of the Inventory of Religious Attitudes." The data were analyzed by the X^2 statistic (11, 12). Each individual item of the Inventory was analyzed in a 3 x 2 table, as illustrated in Figure 1.

FIGURE 1

PARADIGM OF THE ANALYSIS OF INDIVIDUAL ITEMS OF THE INVENTORY

	"YES"	"NO"	"?"
PATIENTS	Observed frequency (o) Expected frequency (e) $o - e$	'do'	'do'
NON-PATIENTS	'do'	'do'	'do'

The basic formula used was: $X^2 = \left\{ \frac{(o - e)^2}{e} \right.$. There are 2 degrees of freedom. For significance at the 5-per-cent level, X^2 must exceed 5.991 in value; for significance at the 1-per-cent level, X^2 must exceed 9.210 in value. The former "means" that in only five times out of 100 would a difference as great be obtained, assuming adequate sampling, by chance alone. The latter "means" that in only one time out of 100 would a difference as great as that observed be obtained on the basis of chance alone. The expected frequencies (e) for each cell in the paradigm presented in Figure 1 were computed by the percentage of "Yes," etc., responses, utilizing the total number of responses by both samples. For example, if out of a total of 240 responses to a particular item (by both groups), there were 48 "Yes" responses, 180 "No" responses, and 12 "?" responses, the percentages used for obtaining the expected frequency for each group would be, consecutively, 20 per cent, 75 per cent, and 5 per cent. Table 3 summarizes the detailed analysis of the differences between patients' and non-patients' responses to all of the items of the Inventory.

Discussion

On the basis of the analysis reported above, a number of points may be discussed and commented upon.

1. More than half (55.6 per cent) of all the items in the Inventory discriminated to some degree and in some way between patients and non-patients. Were this the only result obtained, it would be significant in indicating that there are differences in the religious attitudes structure of patients and non-patients. We are aware of the individual nature of our attitudes toward religion, of course, but we can learn—from the filled-out

TABLE 3

A Summary of the Detailed Analysis of Differences Between Patients' and Non-patients' Responses to the Inventory

Category	Frequency	Percentage
Total number of items in Inventory	151	100.0
Total number of items in which a significant difference was found* At 5-per-cent level: 39 At 1-per-cent level: 45	84	55.6
Total number of items in which no significant difference was found	67	44.4
Total number of items in which "Yes" and "No" responses of patients and non-patients were reversed	17	11.2
Total number of items in which the frequency of "Yes" and "No" responses differed as between groups; but responses were not reversed	27	17.9
Total number of items in which the only significant difference was that patients gave the "?" response more frequently	40	26.5

*It should be noted that, out of 151 items, one would expect—at 5-per-cent level—about 7 or 8 items to be significant by chance alone.

Inventories—something about patients' attitudes in general, as well. It is in this sense that the Inventory would be a useful instrument for chaplains in neuropsychiatric hospitals, for it could furnish information concerning areas of religious feelings and attitudes which might then receive concentrated attention in group sessions conducted by the Chaplain Service.

2. Both patients and non-patients occasionally left items blank, although they were instructed not to do so. The extent to which items were left blank was not formally analyzed; however, by inspection, there appeared to be no significant difference between the two groups on this variable.

3. When the items which did show significant differences between the two populations were analyzed, it is noted that nearly half of the significant ones differed only in that patients gave the "?" response more frequently than did non-patients. The "?" response (and this was emphasized in the original instructions) was to be used only when the individual filling out the Inventory was uncertain or unsure as to what his feelings really were so far as that particular item was concerned. It is significant that the patient population, without exception, used the "?" response more frequently than did the non-patient population. While it may perhaps be argued that this response was a function of the patients' difficulties in understanding the meaning of particular items, this could not be the explanation in every case. Patients were given freedom to ask questions about the wording and meaning of any of the items, and many of them did so. Hence we must assume that for the most part they did understand the meaning of the

items; and therefore that the "?" response reflected a greater degree of uncertainty and unsureness as to what their religious feelings and attitudes were. Non-patients tended to be much surer of their feelings. The unsure response is apparently associated with the lowered self-confidence, the more confused feelings generally, of the patient population. One possible, more positive, suggestion could be that the patients were doing more seeking than were the non-patients. This was not generally borne out by clinical observations, and, unfortunately, could be tested only by having patients fill out the Inventory again after their recovery and discharge from the Hospital. This was not possible in the present study. Data and evidence incline toward the conclusion of more uncertainty and unsureness among patients. This is not a position of strength, and it further suggests that the patients will find it difficult to utilize positive religious feelings as a factor in their recovery. This finding from the results of Revised Form II of the Inventory is clearly associated with findings from Form I, namely, that in the latter a considerable percentage of patients expressed general religious attitudes of religious doubt, confusion of religious thought, and uncertainty of religious thought and feeling (8).

4. The 27 items in which patients and non-patients differed in the degree to which they gave "Yes" and "No" responses to attitude statements are further evidence of the greater degree of consistency and certitude of religious feelings found in the non-patient population. The association reflects greater stability in the latter population. This association of inconsistency, uncertainty of religious feeling and religious doubt with mental illness does not, of course, establish a causal relationship between them. It does suggest, however, that, other things being equal, individuals with knowledge and awareness of their religious attitudes and certainty in their religious feelings tend to exhibit less emotional disturbance. This statement, if verified by other studies in the area of religious behavior, has important implications for religious education.

5. There were 17 items in the Inventory (11.2 per cent of the total number of items) to which the responses of patients and non-patients were reversed. That is to say, if patients answered "Yes" to a certain attitude statement, non-patients were found to answer "No." These are certainly the most significant of the differences found between the two populations. Analysis of these 17 items, as well as of the 27 mentioned in paragraph 4 of this section, document the conclusion that non-patients tend to feel that God is less punitive, more flexible, and more sympathetic. On the other hand, patients felt that God was more vindictive, more controlling, and less forgiving. For example, patients tended to feel that "God hates wicked people" and that "God is against those who do not go to Church." Patients tended to associate failure in life with God's punitiveness and clearly perceived such failure as being in accordance with God's plan. From clinical observation, it is clear that failure in life was associated, by the patients, with their illness and their recurring inability to achieve emotional

stability. Patients agreed that failure in life was due to "God's punishing us for our misdeeds." Responses to two other items in this area were reversed by patients and non-patients. To the statement that failure in life was due to the fact that "we have not been true followers of Jesus," patients answered "Yes;" while non-patients answered "No." Again, to the statement that failure in life is "in accordance with God's plan," patients answered "Yes," and non-patients answered "No." In the category of punishment, also, it should be pointed out that patients tended to give "?" responses to a greater degree than non-patients to the statement that "punishment can change our character." The results of our study are in general accord—with respect to attitudes toward God—with those obtained by Nilsen (5), who found evidence of a high correlation between the idea of a "strict" God and a "lowered self-evaluation;" with "subsequent narrowing of life space and proneness to emotional instability and social maladjustment."

Patients tended to view prayer in a more magical framework; or perhaps it would be more justifiable to say that they perceived prayer as a means whereby they could secure material benefits. More patients than non-patients felt that prayer might be used to "punish their enemies," to "provide employment when one is out of a job," and to "assure them of safety when driving a car."

Significant differences appeared in the area of immortality. Patients again expressed considerable more doubt and uncertainty as to whether or not there was a life after death or, even if so, what that life would be like. To a significantly greater degree, patients felt that the "soul would be merged in a world of spirits." Non-patients tended to express an attitude towards immortality that was more realistically in line with Christian teachings and tradition.

When patients were more positive in their expression of attitude and feeling, it was frequently in a literalistic and religiously immature sense. The Bible, for example, "must be believed from cover to cover" and "every statement in the Bible is true because it is in the Bible." Further, patients to a significantly greater degree than non-patients felt that "success comes to all true followers of Jesus." Stress was placed on the outward observance of rule and regulation rather than upon the inner spirit. Hence, "it is wrong to do essential work on Sunday," and "giving a reasonable percentage of our income to the Church will assure spiritual satisfaction."

In yet another area there was a difference. Patients tended to perceive God as being a more controlling Being; and perhaps themselves as being more submissive and passive. Stated another way, this may reflect a feeling that they are not responsible for their own behavior. Patients tended to answer "Yes" to a greater extent than non-patients to the statement, "God has made plans for all human beings, which they must follow." The feeling that failure in life is due to the fact that "we have not been a

true follower of Jesus" also falls in this category. Further, to the statement that "God has made a blueprint for our lives, which we must follow," patients' and non-patients' responses were reversed. Patients answered "Yes"; non-patients, "No." The desire of patients to avoid responsibility for their own behavior was also significantly expressed in their response to an item in the section dealing with the child who was struck and killed by a drunken driver. Patients, to a significantly greater degree, felt that the "people who sold the drink to the driver were partly responsible" for the child's death.

A reversal of responses occurred in the area dealing with reasons for honoring our parents. Patients responded "Yes" to a greater degree than non-patients to the statement that we honor our parents because the "community will then speak well of us." At the least, this is a distortion of feeling for one's parents.

6. Attention is called here to the similarity of results obtained from the two forms of the Inventory. Concern over punishment; feeling that illness was a punishment for sin; ambivalence of feelings toward God; God viewed as punitive; feelings that illness and failure in life are associated with punishment; and the adoption of religious behavior for materialistic gain—all reflected in the results reported for Form I (8)—have been statistically verified from the analysis of the results of Form II.

Summary

Revised Form II of the Inventory of Religious Attitudes was administered to 120 newly admitted Protestant patients on the Acute and Intensive Treatment Service of the Veterans Administration Neuropsychiatric Hospital between November 1956 and August 1958. This Inventory was also administered to 131 persons, from various groups, who were non-patients ("normals"), and who showed no neuropsychiatric symptoms. The "Yes," "No," and "?" responses of the two groups to the 151 items of the Inventory were tabulated as to frequency, and analyzed by means of Chi-square. Eighty-eight of the 151 items were found to discriminate between patients and non-patients at or better than the 5-per-cent level of significance.

Forty of these 84 items differed only in that patients gave a "?" response more frequently than did non-patients, reflecting unsureness, uncertainty, inconsistency, and doubt so far as religious attitudes were concerned.

Patients to a greater degree than non-patients felt that God was more vindictive, more controlling, and less forgiving. Failure in life (which to many patients was associated with their illness) was clearly perceived by patients to be an indication of God's punishment. Prayer was perceived by the patients as a means by which they could secure material benefits from God; and considerable doubt was expressed regarding immortality.

Attitudes that could be considered religiously immature were more frequently expressed by patients than by non-patients. Frequently, patients showed a literalism, e.g., by affirming "we must believe the Bible from cover to cover," to a greater degree than did non-patients; and stress was placed on outward observance of rules and regulations rather than upon the inner spirit.

In conclusion, the Inventory of Religious Attitudes has been found to provide a relatively quick and thorough means of assessing the patient's religious attitudes. This assists in understanding the patient and in counseling with him. The Inventory could be profitably used by Protestant chaplains in other neuropsychiatric hospitals. One final word of caution is necessary: the Inventory is not designed for—and should not be used in—the parish ministry.

REFERENCES

1. Allport, Gordon W.: *"The Individual and His Religion;* New York, Macmillan, 1953.
2. Boisen, Anton, "The Therapeutic Significance of Anxiety", *Journal of Pastoral Care,* 1951, Vol. 5, 1-11.
3. Boisen, Anton, "The Genesis and Significance of Mystical Identification in Cases of Mental Disorder," *Psychiatry,* 1952, Vol. 15, 287-296.
4. Boisen, Anton: *Religion in Crisis and Custom;* New York, Harper, 1955.
5. Nilsen, Einar A., "The Idea of God and Personality Integration with Special Emphasis upon the Self-Evaluation as a Deciding Integrating Factor," Ph.D. Dissertation, Northwestern University, 1952.
6. Oates, Wayne, "The Role of Religion in Psychoses," *Journal of Pastoral Care,* 1949, Vol. 3, No. 1, 21-30.
7. Oates, Wayne: *Religious Factors in Mental Illness,* New York, Association Press, 1955.
8. Reifsynder, W. E., and Campbell, E. I., "Religious Attitudes of Male Neuropsychiatric Patients, I: Most Frequently Expressed Attitudes," *Journal of Pastoral Care,* 1960, Vol. 14, 92-97.
9. Rutledge, Aaron L., "Concepts of God among the Emotionally Upset," *Pastoral Psychology,* 1951, Vol. 2, 22-27.
10. Southard, Samuel, "Religious Concern in the Psychoses," Unpublished paper, 1954 (and personal communication).
11. Edwards, Allen L.: *Statistical Analysis;* New York, Rinehart and Company, 1946, pp. 239-254.
12. Edwards, Allen L.: *Experimental Design in Psychological Research;* New York, Rinehart and Company, 1950, pp. 80-86.

INTERPERSONAL GROUP SEMINAR: A Training Method in the Pastoral Care of Groups

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For many years now the Interpersonal Group Seminar has been a part of the clinical pastoral training program at the Boston State Hospital.[1] We have always included it for it affords the seminarian or pastor the opportunity to experience and observe the development of group processes as a participant member. It is our conviction that the pastor does much, if not most, of his work with parishioners in groups, yet he has little opportunity to study small-group processes thoughtfully and at first hand.

The form of the Interpersonal Group Seminar grew out of our hospital's training program for leaders of group therapy. In 1946, members of the staff at Boston State Hospital pioneered in the use of group experiences for the therapy of our patients.[2] It soon became evident that leaders of these groups needed a first-hand experience of group life themselves if they were to function effectively. As experience with the training of leaders accumulated, certain consistencies emerged: (*a*) the ideal minimum and maximum number of members ranged from six to ten, (*b*) the ideal length of a group session was 1½ hours; (*c*) a series of thirty sessions was the minimum in which the major issues in group interaction could be expected to emerge; (*d*) such issues were helped to emerge by the use of a rather simple contract in which the structure (time, place, and duration), purpose, and method of the training experience were stated.

The Interpersonal Group Seminar follows the above general outline. Composed of six to ten seminarians and/or pastors with a chaplain supervisor or assistant supervisor as leader (there may also be an assistant leader), the group meets together for a minimum of thirty 1½-hour sessions (three times a week for twelve weeks) in the same place. The purpose is for the members to study their own group process and relations. The method is to allow them freedom to talk about anything they wish except their personal pasts. The function of the leader is to be there, to observe, and to report occasionally on what he feels is going on.

[1]The Interpersonal Group Seminar is also used in two courses at Boston University School of Theology, both of which meet for two semesters: Interpersonal Relations I and II; Directed Study in the Pastoral Care of Groups, I and II.

[2]The literature on this is far too extensive to cite here, even if restricted to articles by the staff of Boston State Hospital. The reader may be interested in a representative article by Dr. James Mann (5).

In spite of the simplicity of the contract, it can be and often is misunderstood. A common misunderstanding for the group-therapist-to-be is to view the purpo e of the group as therapeutic rather than didactic, that is, he views the group as one whose purpose is to effect therapeutic change in the behavior and/or attitudes of its members rather than to study group processes. Similarly, the pastor or seminarian may mistake the purpose of the Seminar. Its purpose is not to function as a therapy group, although any group may have therapeutic outcomes. Nor is it to fit him to be the leader of a therapy group although, as a training group, it would have the goal (hopefully) of introducing the student to basic group processes—a goal which is shared with all training groups, be they concerned with group therapy, group dynamics,[3] or the pastoral care of groups. Rather the purpose of the Interpersonal Group Seminar is to provide a group training experience in which the would-be pastor can become conversant with the basic issues in the pastoral care of groups.

This misunderstanding also extended to the advanced student who was learning to lead training groups himself. Rather than the above general purpose, he could and often did get caught up in details: whether or not covert hostility toward the leader had been expressed; whether or not the group had developed sufficient freedom in the expression of feeling; how he, the leader, was functioning as an exemplar; etc.

As a result of these and other considerations, beginning in the fall of 1958 it was decided to hold a series of theoretical discussions about the pastoral care of groups by some of the personnel of the Protestant Chaplains' Office at Boston State Hospital.[4] The purpose of this paper is to convey to others who might be interested in this area some of our conclusions. Briefly, it was our feeling that the pastor is vitally concerned with group processes which may be abstractly described as illustrating inclusion, individuation, and responsibility.

Before discussing these in more detail, a further distinction may help to form a better perspective within which to view the pastoral care of groups. In the study of group dynamics a distinction is often made between group task functions and group building or maintenance functions.[5] By the

[3]Group dynamics as a systematic study of small group process received its major inspiration from Kurt Lewin. Presently two loci of the continuing development of his and his colleagues ideas are at the Research Center for Group Dynamics in Michigan and the National Training Laboratory in Group Development at Bethel, Maine. For a list of some of the literature on their interest in training groups, see Appendix A in Miles (6).

[4]Besides the writer, two were Teaching Fellows in the Department of Psychology and Pastoral Counseling at Boston University School of Theology: The Reverend Dr. Emil M. Hartl, Director of the Haydn Goodwill Inn for Boys and presently Coordinator of Rehabilitation at Morgan Memorial, Boston; the Rev. William E. Ramsden, doctoral candidate at Boston University and presently pastor of the Stanton Avenue Methodist Church, Dorchester. Two others occasionally attended: the Rev. Robert D. Richardson, Associate Protestant (Unitarian) Chaplain at Boston State Hospital; the Rev. William Finch, doctoral candidate at Boston University.

[5]An often-cited discussion of this may be found in Benne and Muntyan (1) pp. 98-104.

former is meant all those functions that promote the group's efficiency in getting the task done. By the latter is meant those functions which help the group to grow and maintain itself as a group. Since most groups are considered to be task groups, the latter functions are important only as they aid the former. Thus a choir leader is usually chosen not just for how well he can help to make a group out of the choir members but for how well he can help them in the performance of the Sunday anthem.

In terms of this distinction, it will be seen that a therapy group does not have a task in the usual sense; its only purpose is to help each member in his personal living. It is very evident that this "task" is intimately tied up with the total working of the group, its growth and maintenance as a group. For example, we have found at our hospital that the intention of a leader and group of patients to form a therapy group does not automatically make of them a therapeutic group. About thirty sessions are needed for this "therapeutic culture" to emerge, that is, for that time to come when each member can accept as his own goal the valuation that each of the other members is as important as the total group.

In a similar way, the pastor's basic concerns are not with the evident tasks of many church groups (although these tasks may be very important to the growth of the members and the corporate life of the church) but rather with the issues that make for group growth and maintenance itself, with the community and communing of his people. These concerns, though vitally centered on the individual within the community of the church, are not as individualistic as those of a therapy group.

To summarize, various leaders-to-be are interested in basic group processes but from different perspectives. The leader in group dynamics approachs the study of groups from the perspective of aiding people in their tasks. The leader in group therapy approaches the study of groups from the perspective of aiding people in their individual adjustment. The leader in the pastoral care of groups approaches the study of groups from the perspective of what aids the emergence of a Christian community and, within this, how his parishioners become included, individuated, and responsible. With this background, let us look more closely at these three characteristics.

By inclusion is meant (*a*) the group's including of the member and (*b*) the member's acceptance of this including. Inclusion was felt to be basic because without it a person does not grow in the ordinary human sense, e.g., the French boy named Victor who was discovered in 1797 at the age of eleven or twelve to have lived outside the language and symbolic forms of a human group.[6] Biblically, inclusion is portrayd in Jesus' words:

Come unto me, all ye that labour and are heavy laden, and I will give

[6]A very interesting account of this and Dr. Itard's attempt to teach Victor is contained in Brown (4), the Introduction.

you rest. Take my yoke upon you, and learn of me; for I am meek and lowly in heart: and ye shall find rest unto your souls. For my yoke is easy, and my burden is light. (Matthew 11:28-30)

For the pastor, this is a characteristic of the Christian community. Its basis is not just that of a minimal requirement for survival, for Jesus called people to come near to Him. The only basis on which He excluded was on the basis of exclusion itself—those who excluded others and thus could not enter themselves:

> But Woe unto you, scribes and Pharisees, hypocrites! for ye shut up the kingdom of heaven against men: for ye neither go in yourselves, neither suffer ye them that are entering to go in. (Matthew 23:13)

What opportunities are there within the Interpersonal Group Seminar to observe this basic dimension? From the prior description of the Seminar it will be noted that the membership is closed for the duration of the group. The situation is somewhat analogous to the family: the members did not choose each other, rather they were chosen. The leader is responsible for this. The members may raise questions about it: Who brought us together? Do we want to meet together? Who (for me) is in the group and who is not? Does the group include me? Sometimes a member may be absent or show out-of-field behavior, giving rise to other questions: Why is he absent or bored? Is it that he does not care about the group (us)? Or a scapegoat situation may arise. If so, it is vital that the leader search his own feelings. It may well be that, unaware, he has aligned himself with the rest of the group against the scapegoated member and has not seen the true basis of this maneuver as hostility directed toward himself (exclusion).

Bion (2), in his second article on "Experiences in Groups," cites as basic to the waxing and waning of groups the perception each member has of what the group thinks and feels about him. Constantly, the member is operating from this frame of reference. Yet frequently members and leaders are unaware of the tremendous importance of this simple fact. The Interpersonal Group Seminar is an ideal situation in which to sensitize the pastor to the fact that people are constantly "scanning" the behavior of others for reactions about themselves. Inclusion-exclusion is a predominant theme in all this: Am I still included after having said or done that?

The second characteristic we chose, individuation, is perhaps best seen when put in apposition to its opposite, conformity, and thus made into a dimension. Valued highly in democracy, it may be variously valued in other cultures, societies, or groups. Biblically, this characteristic is based on Peter's confession and the immediate buttressing of this act by Jesus:

> When Jesus came into the coasts of Caesarea Philippi, he asked his disciples, saying, Whom do men say that I the Son of man am? And they said, Some say that thou art John the Baptist; some, Elias; and others, Jeremais, or one of the prophets. He saith unto them, But

whom say ye that I am? And Simon Peter answered and said, Thou art the Christ, the Son of the living God. And Jesus answered and said unto him, Blessed art thou, Simon Barjona: for flesh and blood hath not revealed it unto thee, but my Father which is in heaven. And I say also unto thee, That thou art Peter, and upon this rock I will build my church; and the gates of hell shall not prevail against it. And I will give unto thee the keys of the kingdom of heaven; and whatsoever thou shalt bind on earth shall be bound in heaven; and whatsoever thou shalt loose on earth shall be loosed in heaven. Then charged he his disciples that they should tell no man that he was Jesus the Christ. (Matthew 16:13-20)[7]

The church needs not only included and socialized persons but also individuated ones who can say as Luther did, "Here I stand." Moreover, the church should provide this opportunity for its members.

But it is not as simple as it sounds. Bion (3), in another article,[8] would go so far as to say that, when the members become aware of their individual distinctiveness, panic ensues. Certainly the member comes slowly to the honest expression of his thought and feeling in the Interpersonal Group Seminar and, conversely, the group is slow and myopic in observing the signs of feeling in its members. A large segment of this process has to do with the group's expression and evaluation of negative feelings. They may be the first sign of the member's being "over against" the others. What does a group do with its individuals? Often, pastor and church have had little if any positive evaluation of the negative. Often, in a therapeutic setting, the positive aspect of negative expression is apperciated only in a cathartic sense. But the member's risk of being "an individual one" (Kierkegaard)—"the courage to be" (Tillich)—and the group's genuine and growing appreciation of him are basic and vital processes for the pastor: "and upon this rock I will build my church . . . "

Within the Interpersonal Group Seminar it is that part of the "contract" which permits "talking about anything you wish" that undergirds the possibility of individuation. I say "possibility," for individuation is not made automatic by the conditions that help to make it possible. Conformity, the other end of the dimension, as a group characteristic works in the opposite direction: that of channeling expression. Yet if individuation is what the members wish, it can be seen as a valid statement of their process, "where they are." The leader may so comment. His purpose is didactic, not to effect individuation but to point out its appearing or disappearing.

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[7]Max Weber (8) has pointed out that the recognition of the transcendent (" . . . for flesh and blood hath not revealed it unto thee, but my Father which is in heaven") within the Hebraic-Christian (Prophetic) tradition supports the individual in his emergence from and critique of the community, that this is missing in the Hindu caste system where one's religious duty is lived out via one's being a good caste member.

[8]There is not room to discuss Bion's ideas as he develops them in this article. The reader may be interested in Stock and Thelen's (7) applications.

The third characteristic, responsibility, is usually treated in the literature under the topics of the leadership and the task of the group. Its Christian expression is found in Jesus' thrice-repeated admonition to Peter:

> So when they had dined, Jesus saith to Simon Peter, Simon, son of Jonas, lovest thou me more than these? He saith unto him, Yea, Lord; thou knowest that I love thee. He saith unto him, Feed my lambs. He saith to him again the second time, Simon, son of Jonas, lovest thou me? He saith unto him, Feed my sheep. He saith unto him the third time, Simon, son of Jonas, lovest thou me? Peter was grieved because he said unto him the third time, Lovest thou me? And he said unto him, Lord, thou knowest all things; thou knowest that I love thee. Jesus saith unto him, Feed my sheep. (John 21:15-17)

It is not enough to be a member (included). It is not enough to be a rock (individuated). The Christian is also called to pastor (to be responsible): "Feed my sheep." He is to care about the community and the souls within it, into which he was born and baptized and from which he has received his identity.

Within the Interpersonal Group Seminar the issue of responsibility-dependency is precipitated in the crisis of the members' expectation toward the leader.[9] He does not lead in the way they expect him to. Moreover, they do not trust their own capabilities for leading. They also discover the anxiety that goes with being responsible for the group. Others have all sorts of feelings about their leading. The group may come to the place where it refuses all leadership. But even this may be seen as a working through to an understanding of the place of responsible leadership, the respect for it in each other.

It is hoped that the above discussion conveys some of our thinking about the pastoral care of groups. No brief is made for the specific terms we have chosen; it can be said in many other ways. Nor should these dimensions be solely understood as occurring in serial fashion as they were presented. Even a very young child may be seen as doing more than accepting the includedness proffered to him: He is also an individual, and in minute ways (probably large to him) he is caring about and developing responsibility toward the community in which he dwells.

As we bring this paper to a close, the things that were left out come to mind. Perhaps the biggest issue of all—affection and warmth—was not discussed, nor was the big area of the leader's anxiety. The simpleness of the contract presented does not begin to indicate the great amount of thought and experience with which it is hedged about. Another observation has to do with the effects of training. It might be supposed, for example, that one experience in the Interpersonal Group Seminar makes an "old pro" out of the member if he participates in other similar groups.

[9]For a very vivid and interesting description of this process as viewed from the perspective of the leader's anxiety, the reader is referred to Bion's series of articles in the journal, *Human Relations,* titled "Experience in Groups."

Students have not found this so in practice. This phenomenon (plus the length of thirty sessions) suggests that the "culture" which develops is somewhat specific for each group and cannot be anticipated by the experienced member nor understood without participation.

In summary, since the pastor does most of his work with parishioners in groups, he needs to have a clinical opportunity for studying the processes therein. In the clinical pastoral program at Boston State Hospital, this training-of-the-leader opportunity is provided for (in part) by the Interpersonal Group Seminar. However, the student needs a conceptual framework within which he may look for the processes which are important to the pastoral care of groups as contrasted, for example, with the processes important to the leader in group dynamics or group therapy. It was proposed that three dimensions important to the pastor are: inclusion-exclusion, individuation-conformity, responsibility-dependency. The opportunities for the seminarian or pastor to observe these dimensions within the structure and process of the Interpersonal Group Seminar were then discussed.

REFERENCES

In the Text

1. Benne and Muntyan (Eds.): *Human Relations in Curriculum Change;* Dryden Press, New York, 1951.
2. Bion, W. R., "Experiences in Group: I-VII," *Human Relations,* 1948, 1949, 1950, 1951.
3. Bion, W. R., "Group Dynamics: A Re-View," *International Journal of Psychoanalysis,* XXXIII (1952), 235-247.
4. Brown, R.: *Words and Things, An Introduction to Language;* Free Press, Glencoe, Illinois, 1958.
5. Mann, J., "An Analytically Oriented Study of Groups," *Journal of Psychiatric Social Work,* XX, 4 (June 1951).
6. Miles, M. B.: *Learning to Work in Groups;* Teachers College, Columbia University, New York, 1959.
7. Stock and Thelen: *Emotional Dynamics and Group Culture;* National Training Laboratories, New York University Press, 1958.
8. Weber, M.: *The Protestant Ethic and the Spirit of Capitalism* (Translated by Talcott Parsons); Charles Scribner's Sons, New York, 1958.

General, on Small Groups

9. Cartwright and Zander (Eds.): *Group Dynamics, Research and Theory;* Row, Peterson and Company, Evanston, Illinois, 1953.
10. Hare, Borgatta, and Bales (Eds.): *Small Groups, Studies in Social Interaction,* Alfred A. Knopf, New York, 1955.

General, on Group Therapy

11. Corsini, R. J.: *Methods of Group Psychotherapy;* McGraw-Hill Book Company, New York, 1957.*

*Although an excellent review, it does not cover the view at Boston State Hospital. See Mann (5) above.

THE LIBIDO: A DOUBLE LIFE

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The libido in its modern dress is leading a double life. Far from remaining an obscure psychological theory, it is now involved in man's most persistent questions concerning his existential situation. What is man? What is the soul? How is the *whole* man to find his *whole* soul? Both psychologists and theologians in their search for the answers and the questions are crossing the boundaries of their respective sciences and speaking of the libido with mutual interest. Its nature seems relevant to theological doctrines pertaining to man's nature and the degree of his sin as well as to new psychological insights. In this sense, the libido's double life is recognized—a psychological reality and a theological problem for the *Modern Man in Search of a Soul.*[1]

Sigmund Freud first developed a psychological theory of the libido in order to describe the sexual instinct which acts as a psychophysical process having both bodily and mental manifestations, especially the latter.[2] This process, according to Freud, is the result of man's efforts to relieve his biological and psychological tensions. His theory states that the libido develops through oral and anal stages and becomes the normal and mature manifestation when it reaches the genital stage. It is this concept of a mature genital manifestation of the libido which remains vague and abstract for others within the psychological circle. The activity of the libido in the genital stage, it is argued, does not consistently produce the productive and normal man. It does not explain the outbreak of irrationalism which is not expressed in sexuality but which is found in the mature adult.

Among those who reacted against Freud's theory was C. G. Jung. He believes that the libido ought not to be interpreted solely in terms of the genital and sexual. It is necessary to broaden the understanding of its activity to include the expressions of psychic energy toward the fulfilment of personality goals in general. Certainly the libido is not without its sexual aspect, but it also extends beyond sexuality into other major drives such as power, knowledge, self-esteem. Libido as psychic energy is the movement of unfulfilment and discontent within man. It

[1]C. G. Jung: *Modern Man in Search of a Soul;* A Harvest Book, Harcourt, Brace and Company, New York, 1933. The writers especially recommend this book.
[2]Ernest Jones: *The Life and Work of Sigmund Freud;* Basic Books, New York, 1957, p. 282.

may find expression in concupiscence, in lustful sexuality, or it may find expression in the most elevated and refined forms of self-giving love.

It is this paradoxical role of the libido which has aroused theological interest. Indeed, in his *Systematic Theology,* Paul Tillich has spoken of libido in these terms: "Love as libido is the movement of the needy toward that which fulfils the need."[3] The fulfilment of this need assumes many roles in the human scene, illustrating the relevance the libido bears to the doctrines of man's existential state and his condition of sin. To indicate this relationship, it is helpful to use Tillich's understanding of man's existential condition.

Four categories characterize man's finite existence: time, space, causality, substance. Each of these categories shows a characteristic aspect of man's estrangement. The realization of time and its fleeting quality urges man on to grasp each moment, often filling it with content beyond its capacity. The attempt is hopeless on his ordinary level of existence. The presence of space around man, of objects near him, gives man the desire in his insecurity to absorb into himself all which is. Likewise, the evidence of causality urges man to become intellectually the First Cause, and, in similar manner, to give his soul the quality of substance which he sees in the solidity of elements around him. Thus within the very conditions of man's life come the possibilities for sin.

It is, however, the existential category of space—man's desire to absorb within himself that reality which stands against him—which is particularly related to the activity of the libido. Man in his desire to draw all reality into himself—to become the master over nature—commits the sin of concupiscence. In this condition he ignores the destiny of his essential nature by finding his fulfilment solely in the realm of creaturehood, of space. During this process man's libido is turned inward and downward, becoming destructive. This leads to what Santayana calls the true vice: "human nature strangled by the suicide of attempting the impossible."[4]

Psychologically, the libido's role in sin as concupiscence may be regarded as a fixation—fixation upon the self. When man is fixed upon himself as the object and center of his attention, he finds himself quite off-balance, disturbed, unsatisfied, restless. Life tends to lose its savor; it becomes meaningless because man's energies are being directed into a dead-end, into a position from which there is no easy exit. "The wages of sin is death." But, interestingly, it is just at this stage that the libido can become constructive—that man can open himself to that acceptance which is salvation. It is just here that man begins most earnestly to

[3]Paul Tillich: *Systematic Theology,* Vol. 1; University of Chicago Press, Chicago, 1951, p. 280.

[4]George Santayana: "Dickens," in *Modern Literary Criticism, An Anthology,* edited by Irving Howe, Beacon Press, Boston, 1958, p. 124.

long for that which he is unable to find within himself as he presently understands himself. He yearns after that which will give him the power to channel the movement of his psychic energy, his soul force, his libido, outward and upward rather than inward and downward.

In this process of awakening to salvation, the libido in itself is not to be considered a sinful element in any final sense. In many, if not most, men it is sinful, but not inevitably. Freud was correct so far as some men are concerned, but his analysis was far from the profounder Christian understanding which deals with man's essential as well as existential state. Highly relevant to the activity of the libido, then, is a consideration of the means by which it is directed into the channels of salvation. How does a man who is guilty of the sin of concupiscence and who is permitting his libido to wreck his life because of his improper channeling of it manage to correct his sinful state?

The "natural" way of approaching man's problem is correcting such a sinful condition of libido-impelled, self-fixated concupiscence would be to start a simple, straightforward, rational analysis of the individual self. As Cassirer observes, man is a "creature who in every moment of his existence must examine and scrutinize the conditions of his existence."[5] But it is not enough to stop with a self-analysis based on the commonly accepted rational standards, for it is the self who has accepted these standards and who transcends them. The analysis must go beyond the rational and into the area of the depths of the self not revealed by consideration of external circumstances and candid self-questioning.

It is at this point that the human mind often retreats in despair, calling a halt to the going beyond the rational. Man recognizes the limits of reason, but he is not foolish enough to abandon it because of its frailty. In this decision, he is wise. However, man is not left alone when rationality fails to bring *full* self-revelation. He still has the gift of the libido, the wondrous gift of being able to create and to receive myths. If myth is understood as the making articulate and communicable the depths of reason-transcending reality, it is easy to see how it has in it that which will restore balance to the man who is victim to the sin of concupiscence. The real substratum of myth reveals in emotional tones to man that reality which he can never absorb into himself without tragic consequences. This is the reality of essence which cannot be found in the existential conditions of man's being. It goes beyond what man can absorb into himself, causing within him that anxiety of non-being, of being empty and unfulfiled. In this, the myth forces the libido to seek another "out" from the prison of self-absorption.

In this view of myth and libido, a view closer to Jung and Tillich than Freud, the libido is seen responsible in a way for man's myth-making.

[5]Ernst Cassirer: *An Essay on Man;* Doubleday, 1944, p. 6.

In turn, the myth becomes in a way responsible for the direction which the libido takes. Myth may force a misdirected libido, or challenge such a libido to cease its support of the concupiscent self-fixation of a specific individual. Those who have concern for the development, proclamation, and "handling" of myth have the enormous responsibility of so acting as to make myth such as to call the libido to the truths of existence. The emotional language of the myth is to call the psychic energy of man outward to learn these truths, to ask the question concerning the ultimate ground of being, the question of God. As Tillich's categories cited above express the union of being and non-being in everything on the existential level, they raise the problem of the courage to accept the anxiety of non-being or death. They bring man as expressed in myth to the question of God, which "is the question of the possibility of this courage."[6]

It is now conceivable that the libido has a life and mind of its own. Jung believes that this is true. In his own unique way he gives instructions to man for calling the life of the libido outward in this quest for the truth of existence. One task for man is to recognize that sin is psychic concealment which produces more destructive results on the unconscious level than on the conscious level. A man who commits the sin of concupiscence, for example, is demanding that the unconscious element of his life bear the result of his act. The continual drawing in of reality upon the self, the search "to have," the turning of psychic energy inward, have consequences which destroy the source of longing for the truth of existence and for salvation within man. The force which hurls man out of this condition must come from within, for reality (external) is his slave and conscious self-knowledge is his dupe. Thus Jung conceives of the longing for salvation as being grounded in the advancement of the psychic life. This movement outward of the libido requires no little pain. The opening-up of the unconscious always involves an outbreak of spiritual suffering—spiritual in the sense that now the whole man "sees" with his whole soul the existential conditions of his existence. He is able to ask the question concerning the ultimate ground of being and to find the courage of accepting his finitude. However, if the choice is not made to enter into this spiritual risk, man may become the individual who:

> —has no love, only sexuality . . .
> —has no faith, because he is afraid to grope in the dark . . .
> —has no hope, because he is finally disillusioned by the world and life . . .
> —has no understanding, because he failed to read the meaning of existence.[7]

It is not irrelevant or irreverent for theologians to consider the libido as a powerful factor in the spiritual life. When the libido is released from

[6]Tillich, *op. cit.*, p. 220.
[7]Jung, *op. cit.*, p. 226.

inward conscious domination or outward irrational motivation, it becomes the energy with which man can empty the self for the invasion of God—an invasion which is continuously present. It can constructively deprive man of all images when spiritually directed in order to prepare the self for what St. John of the Cross calls the "ray of darkness" of God. The contrast between this imageless condition in the developing spiritual man and the imageful condition found in the sinner is unparalleled. However, this imageless spirituality open for the invasion of God, the very opposite from concupiscence, is far up the road from the beginner's efforts toward the spiritual life. Yet this is the point where Christian love becomes possible in both its dimensions: self-love and outgoing love for others. The unconscious distortion is corrected, as Tillich teaches, as the libido is reunited with the other levels of man's nature. The sin of concupiscence in this condition becomes impossible for the *whole* man. He now has the courage to face his finitude and to ask that one question demanded of him, the question concerning God.

ON LISTENING TO ANOTHER

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What does it mean to listen to another? It means at least five things:

1. Someone is speaking.
2. What he says matters to the speaker.
3. Someone is listening.
4. What is said matters also to the listener.
5. Through the speaking and the listening something happens to both the speaker and the listener.

Someone is speaking. Another being, another self, another person, another "I" is *there.* When God speaks, He says "I am that I am," the Unconditioned. When a person speaks, he cannot say he is unconditioned, but he does say "I am *who* I am." He has an identity, a validity, a value, that define him and no one else. Listening requires that this other who is speaking be recognized in and for himself, who he is, a person, a creature of God, a living soul, who may not be used or manipulated, commanded or cajoled, derided or condemned, but must be respected, revered, cherished.

He may speak from behind a mask—a mask of vocation, station in life, education, success or failure, a mask of false ideals, of pretended feelings, of artificial manners, a mask of self-protection—but no matter how deceptive or impenetrable the mask may seem to be, behind the mask, behind the "personage," in Tournier's phrase, there is a person; and it is the person I must listen for and to.

What the speaker says matters to him. He has something he wants to tell me, and for the moment it is the most important thing in the world to him. He is suffering from pain, anxiety, fear, guilt; or he has a problem, faces alternatives, is all mixed up, must make a decision; or he needs help, support, or encouragement; or he has some splendid news, or a cause for thanksgiving, or a stunning piece of good luck. Whatever it is, this, here and now, is real and urgent and will consume him if he does not speak.

He may not be able to say it directly; he may be so garrulous, repetitive, meandering, that his words never seem to get anywhere; he may be so inarticulate, unimaginative, dull, as to seem brutish; he may be so ensnared in fantasy or suspicion or self-pity, as not really to know what

Presented as a part of morning devotions at the meeting of the Chaplains' Association of the American Protestant Hospital Association, Columbus, Ohio, February 19, 1960.

he wants to say; he may be so weak or weary, so flat, listless, sick, so near to dying, that he hardly has the strength to speak at all—but whatever it is that is on his mind or in his feelings is the one thing then that really matters.

And it matters so much, that he, the person who he is, is reaching toward me from out of what seems to him to be reality, making a claim upon my time, inviting me to participate in his experience, asking me to take some of the responsibility for his life, pleading for my understanding and affection. "I need you," he says.

Someone is listening. I, too, am a person, a self, who is *there.* I am not only a pastor, a priest, a counselor, performing a function, fulfilling a role: I am a human being, and I, too, have a personal identity, validity, value, that define me, who I am, and no one else. The other who is speaking may have come to me because of my pastoral role and function, but in so far as he communicates his thought and feeling he communicates with *me* the *person,* rather than the pastor as a personage. So it is not the pastor who is listening, but the person "I" in the role of pastor. Through the mask that is placed upon me by my profession, I must reach, by my listening, to present myself to him, attend upon his speaking.

What the speaker says also matters to me, the listener. Simply because this is another *person* speaking, giving me a glimpse of what it is like for him to be who he is, he is telling me something I need to know. He is disclosing another picture of what it is to be a man, and so is telling me something about myself. We are wrapped up together in the bundle of life, each achieving his identity through the give and take of mutual experience. He defines, and so is part of, me; and I define, and so am part of, him. Hence, what he says belongs to, and is important for, not just himself alone, but belongs to, and is important for, me also.

And it matters so much to me that I accept the claims he makes upon me. I give him time, I take a responsibility toward him, I participate in his experience, I try to understand him, I reach out to him in affection because I must, if I am to be myself.

I do not have to defend myself against him, or justify my doctrine, or make excuses for my church, or protect my position as a minister. Since he is part of me, and what he tells me deepens my own understanding of what it is to be a man, I can take up what he tells me into my own world of meanings, without fright or shock or menace. I do not have to silence him, sidetrack him, prevail over him, make him over into an image of myself. I can go along with him, sharing his self-disclosure, feeling out the shadowy reaches that elude articulation, acknowledging each new glimpse of what hitherto was hidden. In effect, I say to him by my listening, "I, too, need you."

Through the speaking and the listening something happens to us both.

There is no such thing as "passive listening"—or, if there is, it amounts to a rejection. For the speaker's words tell me about myself, and challenge either an acceptance or a rejection. If I can accept his words, then I am committed to him, and am no longer a merely passive hearer. In accepting what he tells me, as word about myself, I say "Yes" to both his experience and my own—"Yes, I am with you." I give him of myself.

And so he sees himself, not merely reflected back as from a mirror, but revealed as in a portrait, into which the reality of my experience has also entered. Something thus is added to what the speaker said. A new reality springs up between us, and both of us are changed: I for having seen myself anew in him; he for having rediscovered himself in me. Each of us is recreated. And this essentially is the clue to what happens in the redemptive encounter wherever it occurs in life. It is another way of saying what the gospel is about.

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EDITORIALS

Otis R. Rice

Quite suddenly and with few of us knowing his illness, Otis Rice died July 7th. Since his retirement as Religious Director at St. Luke's Hospital in 1958 little has been known of his activities. He died, much as he lived, a lonely figure. Such, it seems, is often the way of the pioneer. Especially is this true when one is a pioneer in the area of clinical pastoral training, in that vortex which brings religion and psychiatry together. Here one comes to know the anxieties, uncertainties, and confusion which are the lot of even the most ardent seeker. All this Otis knew first hand.

Many tributes have already been and will continue to be paid to his memory. This is no time to list his many "firsts" in our field of concern, or the very distinctive contributions he made. Besides, it would only have embarrassed him. What he did, and he has done a very great deal, few ever knew about. Often those who had cause to be most grateful to him found it well-nigh impossible to make such acknowledgment. Of such is the nature of loneliness.

With these few words many of us want to give thanks for a courageous, sensitive, warm, and very human person. He was known to us only in small part—for he lived his life ministering more to others than he could allow them to minister to him.

E. E. B.

The Seventh National Conference on Clinical Pastoral Education

"Trends in Clinical Pastoral Education: Objectives, Methods, and Standards" is to be the subject of the Seventh National Conference on Clinical Pastoral Education to be held at the Hotel Roosevelt, Washington, D. C., October 27 to 29, 1960. Dr. Seward Hiltner will present the main paper and is expected not only to trace the developments in the field—something he is uniquely capable of doing from extensive first-hand experi-

ence—but also to point up the present major areas of concern as clinical pastoral training continues to make its impact upon theological education. In addition to the four clinically trained discussants of Dr. Hiltner's paper, twelve other leaders will make brief presentations during the three-day conference, thus assuring sufficient current material for active workshop discussion. It is planned to have all papers and a summary of the workshop discussion published as the findings of the Seventh National Conference.

Many of us will watch with keen interest the outcome of this conference. In addition to the workshop discussions it is anticipated that the Advisory Committee on Clinical Pastoral Education will report on the most recent developments and the possible establishment of a national association on clinical pastoral education. Such an organization was strongly recommended by the Fifth National Conference in 1956 and has been the subject of considerable interest and concern on the part of many actively involved with the clinical training movement.

The establishment of an association should become a matter of keen interest on the part of many of the readers of this *Journal.* As a matter of editorial policy, the *Journal* from the beginning has had as one of its stated aims the publishing of materials which share both experience and varied interpretations of clinical pastoral training. This is urgently needed in our time, and we welcome a conference which permits the fullest expression of the many diverse and often disparate points of view in objectives and methods as are found in clinical training programs today. It is to be anticipated that such a conference will provide an invaluable body of source material from which future standards for program content and supervisory method could well evolve. Certainly this is much needed when little work has been done on standards since the major national acceptance of the standards as adopted in Chicago at the Fourth National Conference in 1953.

The development of adequate standards for program and practice in clinical pastoral training on the national level is another important problem facing us. Furthermore there is also the need for more articulate communication with regard to the skills and understandings we have already developed, and these are by no means inconsiderable. Some of this material has already been published in the *Journal,* but there is much more which has not as yet even been formulated, let alone published. It is just in this area that unencumbered leadership on the national level is so urgently needed—and so difficult to achieve with the many different clinical training groups and more springing up around the country. One of our most pressing needs at the moment is sensitive, intelligent, and informal understanding of the national issues, demonstrated through an organization which is keenly aware of the perplexities and confusions which beset us all, and which can provide the kind of leadership which can point us in the direction of a resolution of our concerns. No individual nor any existing organization has as yet provided such leadership. But it may well prove

possible that this coming Seventh National Conference will so delineate the areas of our need in the realm of standards, objectives, and methods that such leadership will emerge. The formation of such a national association, characterized by an identity of its own and capable of offering an over-all leadership which none of us is able to offer singly or as separate organizations, would be a most welcome contribution to promoting the clinical emphasis in theological education.

It is to be noted that in May 1956 the Council for Clinical Training took the initiative through its representatives and unanimously recommended to the then "Committee of Twelve" that a national organization be formed to pursue the major concerns here discussed. This goal has increasingly come to be seen as the means whereby we can share our achievements as well as our problems for the good of educators as well as students in the pastoral ministry.

Should no such national leadership become available at this time, it may well be that we shall have lost our one great opportunity for years to come. Then we may find that pressing research questions will go unasked and unexplored; opposed sets of standards for training methods and program content will spread among us; no reasonable certification and inspection procedures will be available; no adequate administrative policies will have been clarified; and the many progressive steps we have already taken may abruptly come to a halt.

That these are all live issues can be verified by taking only a casual glance at the national scene. Clinical training has been well sold to state institutions supported by government funds, and there is increasing demand for clinically trained chaplains who will conduct training programs as part of their job as state employees. What has not been made clear, or even in most instances come to be seen even dimly as a problem, are the many ramifications which follow when the taxpayer's monies are being spent on theological students while in training. This becomes even more complicated as both Roman Catholic and Jewish clinical training programs get added to an institution's training load, and standards for recruitment, selection, appointment, and teaching in such training programs must achieve some reasonable uniformity to be acceptable in a government institution.

This is just one issue, albeit a very complex one, which has already confronted some administrators and chaplains. Another can quickly be identified by title. To which organization shall a government agency or any employing institution look for certification when it seeks to hire a qualified chaplain? And where are the standards by which clinical pastoral training programs can be inspected and judged when such programs are already in operation?

There are a growing number among us who have become quite concerned that the pastoral quality of clinical pastoral training is often

ignored if not actually missing in many of our programs. There are some who view with alarm that many supervisors are confusing therapy with training, and consequently engage in a very suspect kind of counseling free-for-all with students which leaves the students confused and resentful when they return to seminaries. In some clinical training programs, much time is spent on a free ventilation of personal feelings under the guise of "group therapy," which not only bewilders the student but effectively keeps him from visiting and effecting a ministry of learning with the patients because his anxieties have been so heightened that about all that he can achieve is a self-defeating kind of "navel gazing." This, of course, is not what he came for, nor what the institution wants, nor what is generally believed to be clinical pastoral training. There are already too many troubled people in the world (and especially in the parishes to which our students eventually go) in need of sensitive and clinically informed understanding.

We do indeed look forward with anxious concern to the forthcoming Seventh National Conference on Clinical Pastoral Education. The time is overdue when vigorous, informed, and competent leadership is needed to aid us in our common goal of promoting the clinical emphasis in theological education.

E. E. B.

COMMUNICATIONS

The Institutional Chaplaincy

The largest group of people in this country not yet served adequately by the church are the 30,000,000 residents of public and private institutions. This population represents the number of individuals in the care of an institution at some time during a period of twelve months. These institutions include hospitals for children, mental patients, narcotic users and general patients, training schools, jails, penitentiaries and correctional facilities.

Institutional care represents a crisis for most of these people. It is a time of tension, rapid physical and mental change, along with rehabilitative effort. It is a time when individuals are most open to receiving skilled guidance.

The skill of pastors with insight into the kinds of people they are serving has not yet been widely established in institutions. The 24,000,000 who represent the Protestant portion of the institutional population are at present being served partially by 1,500 chaplains. This is a ratio of one clergyman to 16,000 people.

A clergyman who represents a communion in an institutional ministry is properly designated as an institutional chaplain. He is identified as a pastor or clergyman rather than a counselor, therapist or some other vocational status. He is not a substitute for and does not replace the work of the parish pastor in visiting the sick and needy parishioners in institutions. Clergymen visiting institutions on a part-time basis or in connection with their parish responsibilities are thought of as visiting clergymen rather than as chaplains.

The chaplain is one who has an official staff relationship within an institution and has the primary responsibility for identifying and serving the religious needs of the institutional population.

The days of the free-lance chaplain are about over in areas where standards of good chaplaincy practice have been recognized. Denominational assignment and endorsement are primary signs of a responsible ministry. Other standards for this level of ministry require graduation from college and seminary, ordination, experience as a pastor in a local church, a year of clinical pastoral education, and personal characteristics which would permit effective functioning in an institutional setting.

Experience as a parish pastor is not a substitute for seminary experi-

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ence and background. Experience in an institution is not a satisfactory substitute for supervised clinical pastoral education.

The chaplain becomes a part of the institutional team which ministers to the whole man. Although members of the team have their specialties and responsibilities, each profession ministers to the person rather than to parts or functions of the person. The medical doctor and the social worker will, for instance, be interested in how a person's religious practice or lack of religious practice has contributed to his present condition. Thus the religious program of an up-to-date institution is not the program of the chaplain but is an integral part of the total institutional treatment. The chaplain is the main resource for institutional religious program but is not the program himself.

The chaplain's role changes slightly from one institution to another. He is usually given responsibility as the head of a department and is responsible administratively to the executive officer of the institution. As a team member, he works with men of other disciplines such as medicine, psychiatry, psychology, social work, education, penology and law. As a chaplain, he frequently spends as much time with staff people as with the inmate group. He is sometimes in a pastoral role with employees where there are emergencies and family crisis. With the professional staff he is expected to communicate the meaning of past religious experience of the inmate group and to recommend areas of supplementary religious experience. He is expected to learn from specialists in other disciplines ways to make his own contribution more meaningful to the inmate group.

The particular contribution of the chaplain to an individual may be in terms of religious education, counseling, visitation, worship, sacramental ministry or in helping to provide meaningful relationships with the outside religious community. For the groups within the institution the contribution may be as leader, teacher, symbol of the religious community and always as a witness to the Good News by his presence during crisis and routine living. He is a tangible link to the world of faith, good will and the love of God.

People under stress make many extreme demands upon an institutional staff. A chaplain gets his share of insatiable requests for attention, understanding, love, guidance, assistance, time, wisdom, concentrated concern, continuous planning and effort. Personal characteristics involve a self-knowledge on the part of the chaplain to the point where he comes to terms with his mission. He will need to remain sensitive to suffering individuals without being maudlin. He will have some understanding of his own defense mechanisms, where they prevent an effective ministry and where they enable him to sustain a productive life. He will need to be a person who continues to mature in religious faith, who can draw upon spiritual and family resources to meet his own demands for a full life.

As a churchman he will need to be able to conduct his priestly functions without prejudice with all manner of men seeking Holy Communion and Baptism. He will need to be of a communion that permits him to use sacraments outside a particular faith group.

The chaplain as a pastor fulfills the meaning of the shepherding idea. He feeds, nourishes, protects and leads his flock. The shepherding function is correctly applied to the familiar term "cure of souls." The cure of souls refers not just to remedial treatment alone but is better understood as "caring for" his charges. The chaplain as a shepherd, functions not only by reason of his education, skills and experience but as a representative of the God whom he serves.

With experience, chaplains tend to become identified with a particular type of institution and do not appear comfortable if appointed to an institution serving other kinds of needs. One indication of this kind of identification is in the development of four national chaplaincy organizations. The Mental Hospital chaplains meet with the American Psychiatric Association. The American Protestant Hospital Association sponsors the general hospital chaplains as a professional group. The Correctional chaplains meet with the American Correctional Association. The Association of Training School Chaplains is planned to meet the needs of those individuals working in training schools. Each of these groups appears closer to the kind of institution they serve than they do to other chaplains.

The process by which a man is placed as a chaplain in a public institution is shaping into a pattern. In fifteen states the state council of churches has been designated as the nominating agency. The trend is toward such procedure in other states. Nomination is based on standards adopted by both the state and the council.

The person having the last word is the institutional executive who makes the appointment. He may be a warden, superintendent, or someone designated by the governor of the state.

Where suitable standards are in operation, political considerations drop out. A recent survey by the Department of Pastoral Services of the National Council of Churches indicates that twenty-three states have no formal standards. The salary scales for chaplains follow the standards by which men of competence are selected. Salaries tend to be inadequate where there are no standards. Individuals interested in the standards of a particular state should write to the state council of churches for information. For national standards write to the Department of Pastoral Services, 297 Fourth Avenue, New York 10, New York.

As a part of the nomination process, the nominating agency requests denominational endorsement of the chaplain's communion. The denominational endorsement is a statement of the candidate's ordination, of his good

standing in the denomination along with approval and support for the candidate to accept the appointment.

The nominating agency should request endorsement from the highest denominational channel provided. Twelve denominations now have an executive at the national level to provide assistance for chaplaincy appointments.

The nominating agency takes responsibility for selecting candidates who meet all the standards. A statement is secured from the clinical training organization showing the satisfactory completion of clinical training. This statement may include a quality evaluation as well as an indication of the period of time over which the training was experienced. The nominating group is careful to follow up all references in the application. Psychological testing and a psychiatric evaluation may be provided where more information is needed. The appearance of the candidate before the nominating committee is routine.

The processes of denominational endorsement, nomination and appointment are frequently confused by the applicant for a chaplaincy. They need not be confused if the denomination is remembered as the organization which gives the chaplain his ecclesiastical standing. The training organization certifies the period of clinical training. Nomination is by the organization which gathers the credentials and makes the decision that the applicant is qualified to represent the Protestant community. The appointment is made by the hiring agency.

A relatively new development in civilian chaplaincy is denominational endorsement on an annual basis. Such a program has been in effect between the Federal Bureau of Prisons and its chaplains for the last two years. This is providing a pattern for the annual endorsement of chaplains in other public and private institutions.

Annual endorsement is seen as a means of developing responsible interest of communions in its institutional chaplains and as a means of indicating the concern of the churches to the institution for an effective religious program. The process tends to improve the level of chaplaincy operation by giving the chaplain evidence of denominational and ecumenical support for his ministry.

The clinical training requirement for chaplains has been developed out of the need to provide pastors with an understanding of people in crisis. Clinical training consists of supervised experience as a pastor, with people in various stages of physical, emotional and spiritual stress. The supervision is provided by a chaplain supervisor accredited by one of the established clinical training agencies.

A candidate for training will do well to consult his seminary or denominational offices for guidance in the selection of a clinical training source. At

least a dozen new clinical training agencies have developed in recent years and months. Our evaluation is that these agencies represent several levels of pastoral care, maturity of supervision, and goals of training.

It has not seemed wise to substitute other kinds of experience for clinical training. Experience as an orderly in a hospital may contribute to the training of a future medical student but does not make him an effective doctor. In like manner periods of unsupervised pastoral experience in a community or institution does not provide adequate background for an effective chaplain. The same statement can be applied to academic training as a substitute for clinical experience.

The number of clergymen needed to minister as qualified chaplains in institutions appears to increase each year. The combination of being a pastor where people constantly seek assistance, where teamwork with other professional disciplines is a necessity, and where one's faith and theology are tested clinically is an irresistible calling. It is our feeling that the growing edge of pastoral care, theological development, and the emphasis of the churches that was the missionary movement fifty years ago is now being found in the ministry of institutional chaplains.

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BOOK REVIEWS AND NOTICES

Edited by The Rev. Rollin J. Fairbanks

Personality Patterns of Psychiatrists: Robert R. Holt and Lester Lubersky; Basic Books, New York, 1958. 386 pp. $7.50.

We have here the first report on a "ten year effort to learn how residents were being selected for the Menninger School of Psychiatry." As could be expected coming from this renowned center of intensive treatment, training, and research, one looks for major contributions in so all-important an area of concern. And the reader will not be disappointed. If, however, definitive answers are expected—if clear-cut *guaranteed* formulae for selecting candidates for such close working relationships with people as is demanded of psychiatrists are hoped for—then this will be a frustrating book. There has been a current rumor to the effect that the study 'proved only one thing: that you could prove nothing in so complex an area as that dealing with the human personality when it comes to predicting what makes a good or poor psychiatrist.' But the study nevertheless has contributed an invaluable, massive, as well as impressive body of clearly delineated research data dealing with personality attitudes. For this all those engaged in interviewing and recommending for selection candidates for the helping professions will be forever indebted.

In proceeding with the research design it was seen clearly that the data for adequate candidate selection have to include: (1) a clear definition as to what a psychiatrist does; (2) what one looks for, i.e., what qualities in the person; (3) how one goes about it, i.e., by what techniques can such evaluation be achieved; and (4) the ability to recognize the qualities established and sought, when and if they are found. It is in just these areas that the authors have done much to help us.

For this reviewer, having now been active in the psychiatric-psychological screening of students for the Episcopal ministry for the past thirteen years, the chapter dealing with "A Survey of Expert Opinions on Personality Requisites for Psychiatry" was particularly illuminating. Especially helpful are the five pages of charted requisites found on pages 267-271.

The real wealth of readily applicable and measurable findings are to be found in Chapter 17, which deals with "Recommendations." Here we are given a significant body of data which could gainfully be tested both clinically as well as at the research level. For purpose of convenience this material is topically listed between pages 143 and 145. The authors do not hesitate to become specific and, on the basis of their experience, they offer twelve recommendations for procedure with regard to selection and an equal number of specifics for follow-up research. Such willingness to "go out on the line" ought to encourage others not only to experiment with new media but equally to subject them to research scrutiny.

Perhaps one of the most provocatively efficient short sections dealing with interviewing is a very human and insightful personal letter by Dr. Lionel Blitzsten, the late Chicago psychoanalyst of such warm-hearted therapeutic fame. Dr. Blitzsten clearly outlines his own technique for interviewing. This brief outline will prove an invaluable guide to all who are seeking to develop some proficiency in this complex and confusing area of human service. But it must be emphasized that even this friendly and warm description of a great-hearted person's technique must be learned in such a way that it becomes a technique only after it has become a part of the way that a given human being functions most comfortably and helpfully.

Those responsible for a similar kind of interviewing will be deeply indebted to the authors for their careful work. The time has now arrived that, with such a helpful guideline and the wealth of clinical data at hand, church-concerned administrators should provide for research investigations which will make more sensible and useful the almost hit-and-miss methods used by many ministers and pastors in caring for souls in distress. Too long have we clergy been "the blind leading the blind" or, even worse, just "going on feeling," when what we need is a means to discover more of what it really means to be "inwardly moved and truly called." This volume does much to help us move in that direction.

It should be mentioned that, with eleven pages of carefully selected bibliographical material and ten pages of index, we have an excellent resource for further study and research.

ERNEST E. BRUDER

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Beyond Freud, A Creative Approach to Mental Health: Camilla M. Anderson, M.D.; Harper and Brothers, New York, 1957. 282 pp. $4.00.

In her last chapter, a brief one entitled "Religion and Psychiatry," Dr. Anderson confesses: "As I became increasingly emancipated from the Freudian doctrine, a freedom for dealing with the whole person emerged, and I found myself confronted in every patient, not with unmanageable Id drives, but with the most elaborate and individual value systems which permeated into every nook and cranny of their lives and were the fountainhead of their conduct and their symptomatology." This book is an exciting development of the place of the individual's assumptions, his "value system," or private religion, as determinative of his behavior, his symptoms, and his style of life. It is a book that deserves to be read twice by those with a vested interest in religion. There should be a respectful interval between readings to permit the reader to adjust to the changes in his own value systems that a serious first reading may provoke.

Aside from the major contribution of this volume mentioned above, there are a few warnings which should be heeded. First, the book jacket asserts that the style is facile, direct, and free of cultist jargon. This is only partially true. Dr. Anderson creates her own jargon. For example, in speaking of the structure of defenses, she asserts: "If the structure is maintained intact and the response or the functional result obtained on putting it into operation is different from, or contrary to what is anticipated (according to the conceptual unit of structure-function) the person experiences

the feeling of frustrated entitlement." In context this makes sense, but it is still Anderson jargon. Therefore the first warning is that one needs to be prepared for Dr. Anderson's unique way of putting things.

To the standard classifications of character types recognized in the Diagnostic and Statistical Manual of the American Psychiatric Association, Dr. Anderson adds one of her own. In addition to the hysterical character, the obsessive compulsive, the paranoid, the psychopath, and the schizoid character, she adds "Association Deficit Pathology," a syndrome which results from cerebral anoxia. More is made of this early in the book than is of interest to clergymen who are not qualified to evaluate adequately the appropriateness of this addition to psychiatric nomenclature. But the reviewer cannot help wondering if this syndrome might not serve the function of a waste-basket classification. The second warning, therefore, is not to allow "Association Deficit Pathology" to become a stumbling block to the many exciting considerations Dr. Anderson has to present to those interested in religion and mental health.

Most of this book falls into that area which is of common interest to those trained in religion and to those trained in psychiatry. Dr. Anderson believes that psychiatric illnesses are illnesses of the soul, and that psychotherapy is an experimentation with new assumptions or values. Someone who believes this deserves to be read by those who take religion seriously.

MAURICE C. CLARK

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Retarded Children: God's Children: Sigurd D. Petersen; Westminster Press, Philadelphia, 1960. 156 pp. $3.00.

Parsons State Hospital and Training Center was established in 1953 by the state legislature of Kansas "for the purpose of care, treatment, and training of retarded children within the age limits of six and twenty-one." The Rev. Mr. Petersen is the chaplain at this institution which now has more than 600 patients. In this interesting and inspiring little book he attempts "to give a verbal picture of what a chaplain for retarded children has seen and experienced in the past four years," hoping that he "may be able to transfer some positive feelings about these children to those who read these pages."

Chaplain Petersen's contention is that "retarded children are real persons and therefore significant to both God and man; that they can respond in meaningful ways, and because they can, the manner in which they are received and treated becomes a religious concern; and finally, as they too are the objects of God's redemptive love they must be conceived of as members of the household of faith, the Christian church." With this underlying thesis he treats his subjects under these chapter headings: "Religious Responses," "Persons," "Children with Problems," "Children in Real Trouble," "Treatment," "Living and Learning," "The Parents," "Religious Needs," A Theology," and "Implications." Many individual case histories document the material presented.

The chapter on "Implications" contains the author's recommendations

for parents of retarded children and suggestions as to what the church can do for these children. Appendices present descriptions of the five functional levels into which the children at Parsons are grouped and the objectives to be sought for the children at each level, as well as the services of worship for both the children's service and the youth service. A bibliography of 25 titles is appended.

LUBERTA M. MC CABE

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Family and Class Dynamics in Mental Illness: Jerome K. Myers and Bertram H. Roberts; John Wiley and Sons, New York, 1959. 295 pp. $6.95.

This is the second report on a major research study on interrelationships between social stratification and mental illness in a New England urban community. The first was published in 1958 by Hollingshead and Redlich as *Social Class and Mental Illness*. Two major questions were the focus of concern in the second report: Are social and psychodynamic factors in the development of psychiatric illness related to a patient's position in the social class structure of American society? Is mobility in the social class structure associated with the development of psychiatric illness?

This is a fascinating, well-documented and lucidly written volume. It presents an abundance of data and questions that give real clues to the most pressing issues involved in mental illness. It points up graphically what many have come to suspect, even though not too clearly, that "the social environment in which men live is related in some way, not yet fully explained, to the development of mental illness." What is particularly heartening is that the study is well aware of, and attempts to compensate for, the "traditional psychiatric theory (where) the mentally ill individual is viewed as an organism and little attention is paid to him as a person in a social system." The family is seen as the locus of concern to ascertain where class structure and individual development of illness connect.

This study contributes significantly to the understanding of any serious investigation of interpersonal relations. There is abundant evidence that social attitudes contribute to the genesis, meaning, and treatment of mental illness. In a day when we have become rather sharply aware of the vast discrepancy between our stated values and demonstrated behavior it behooves us to listen to those who have taken some pains to investigate these phenomena on a clinical basis.

Of course there are criticisms of the study. Fifty families are all too few. New Haven has a character of its own. There was no control group, and the investigators still seem to be blinded by the all too prevalent concept that it is possible "to study the patient." But the earnest pastor, baffled by the many instances of deeply troubled people he finds in his pastoral work, will learn much from this report. The minister intending to specialize in counseling or in the teaching of clinical pastoral education or training should not neglect this fruitful and highly provocative study.

ERNEST E. BRUDER

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Marriage and Personality: Ainslie Meares; Charles C. Thomas, Springfield, Illinois, 1958. 157 pp. $3.95.

The author, an Australian psychiatrist, has prepared "A Psychiatric Study of Inter-Personal Reactions for Student and Layman." As the title of the book indicates, however, this "study" is directed solely to the marriage relationship itself. The presentation is fragmentary. The observations resemble vignettes such as an author of a syndicated advice column might produce. While admittedly comprehensive in scope, the approach at times seems over simplified and the psychiatric concepts and terminology are somewhat dated in comparison with the current dynamic psychiatry encountered in this country.

Dr. Meares has recognized the many dimensions and components of the marriage relationship, and in setting them forth he makes a real contribution to the increasing literature on marriage. It is to be regretted, however, that no index is provided.

ROLLIN J. FAIRBANKS

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The Introvert: Ainslie Meares; Charles C. Thomas, Springfield, Illinois, 1958. 147 pp. $4.50.

This volume is not written for the professional person. The reader will be disappointed if he hopes to gain either an understanding of the etiology of introversion, or assistance in working therapeutically with the introvert. The author's aim and his achievement are to discuss the social adjustment of the introvert personality in both the male and female child, adolescent, and adult. Although he admittedly avoids a definition of introversion, Dr. Meares describes well how the shy, self-conscious, withdrawn, schizoid individual feels, and how his feelings affect his behavior. Hence this book might be of help if offered by the pastor to some anxious or unsympathetic member of an introvert's family.

MAURICE C. CLARK

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Death and the Christian Answer: Mary Ely Lyman; Pendle Hill Pamphlets, Wallingford, Penn., 1960. 16 pp. $.35.

Seldom do we take space to recognize a pamphlet. In this case, however, we are fully justified in making an exception because of the important subject, the excellent presentation and the wisdom and competency of the author, a Congregational Christian minister and former member of the faculty of the Union Theological Seminary.

With rare sensitivity and deep compassion for the unuttered but gnawing questions that haunt people today, Mrs. Lyman begins realistically with the need for a courageous confrontation of the mystery and impact of death. "To look straight at any baffling situation and face it for what it really is—these are the first steps towards adequacy for meeting it." Avoiding the temptation to compile an anthology of quotations on the subject of death the author has selected carefully though sparsely some excellent statements which illustrate the wisdom she imparts. And throughout it all like

a golden thread there runs the adjective *Christian*. This is Mrs. Lyman's constant point of reference, and we are deeply indebted to her for this wise, comforting, and inspiring pamphlet.

ROLLIN J. FAIRBANKS

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Understanding the Old Testament: Bernhard W. Anderson; Prentice-Hall, Englewood Cliffs, N. J., 1957. 551 pp. $8.65.

Here is a superb companion volume to Kee and Young's *Understanding of the New Testament,* both of which constitute solid background of the Christian faith. Beautifully illustrated and thoughtfully documented, Dean Anderson's introduction to this important but often ignored major section of the Bible should be in every parish library.

Drawing heavily but discriminately upon the accumulated wisdom and insights of archaeological and Biblical scholarship, the author has by means of excellent rhetorical skill and style prepared a book which will be of exceptional value to those pastors whose counseling includes an interpretation of the Christian faith as a way of life.

ROLLIN J. FAIRBANKS

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Holy Communion: Compiled by Massey H. Shepherd, Jr.; Seabury Press, Greenwich, Conn., 1959. 162 pp. $3.00.

The sub-title of this small volume (*An Anthology of Christian Devotion*) is a good description of both intent and content. Made up of prayers, hymns, poems, and meditations—all of which are oriented around the Christian Eucharist—this compilation, thoughtfully documented, offers spiritual stimulation and nourishment for the serious student of the Christian faith. An excellent index strengthens the book's use as a reference. Dr. Shepherd is to be commended for his scholarship and effort.

ROLLIN J. FAIRBANKS

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The New Testament in Modern English: Translated by J. B. Phillips; Macmillan, New York, 1958. 575 pp. $6.00.

Here are all of Phillips' remarkable translations of the books of the New Testament under one cover. Today with our increasing struggle to make the Christian Revelation meaningful to an anxiety-ridden, disenchanted world, we are deeply grateful to this English clergyman for searching out the vernacular which most effectively communicates the message of the New Testament. While Biblical scholars continue to balk on the admitted freedom with which the translator has gone about his assignment, the fact remains that the *spirit* of the Christian message is certainly reflected accurately. While for this reviewer the translation of the epistles (*Letters to Young Churches*) still stands out as perhaps the best of the four volumes (*The Gospels, The Young Church in Action,* and *The Book of Revelation*), nevertheless it is certainly convenient to have the single, complete volume.

ROLLIN J. FAIRBANKS

OUR REVIEWERS

Ernest E. Bruder is Director of Protestant Chaplain Activities at Saint Elizabeth Hospital, Washington, D. C. . . . *Maurice C. Clark* is Chaplain Coordinator at University Hospital, Columbus, Ohio . . . *Luberta M. McCabe* is a housewife in Cambridge, Massachusetts . . . *Rollin J. Fairbanks* is Professor of Pastoral Theology at Episcopal Theological School, Cambridge, Massachusetts.

NEWS AND COMMENTS

The many friends of Chaplain Norman Autton of Deva Hospital in Chester, England, will be interested to know that he launched his first full-time clinical pastoral training at Deva this summer. In a course six weeks in length, six students proceeding toward their final year of divinity training served as orderlies in order to obtain first-hand experience with the mentally ill. Though only limited information is available about the course, it would appear to have been a most significant thrust into Anglican theological education. We would earnestly hope that Chaplain Autton will find time soon to write up in some detail not only his evaluation of the program, but the principles, practices, and objectives which guided him in setting up this pioneer project in England. Such material would be most welcome to the readers of this *Journal.*

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The Rev. Reuel L. Howe, S.T.D., Director of the Institute for Advanced Pastoral Studies, Bloomfield Hills, Michigan, was honored with a D.D. degree from both Whitman College, Walla Walla, Washington, and from the Chicago Theological Seminary. Both these degrees were given in recognition of the contribution of Dr. Howe and the Institute to theological education and to ecumenical relations.

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The American Foundation of Religion and Psychiatry held its Ninth Annual Summer Seminar on Pastoral Care in its new quarters at 3 West 29th Street, New York City, May 31 through June 4, 1960.

The Academy of Religion and Mental Health announces the following forthcoming events:

The Fourth Academy Symposium at Arden House, Harriman, New York, November 18-20, 1960. The theme is "The Place of Value Systems in Medical Education." Attendance at the Symposium is by invitation only. The proceedings will be available in book form at cost through the offices of the Academy.

The Second Annual Meeting of the Academy at the Hotel Biltmore, New York, January 18-20, 1961. Reservations for this meeting may be made through the offices of the Academy, 16 East 34th Street, New York 16.

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Saint Elizabeths Hospital in Washington, D. C., announces the availability of internships and residencies in advanced clinical pastoral training of one or two years' duration beginning in September of each year. Such training prepares a chaplain for certification as a clinically trained mental hospital chaplain or chaplain supervisor.

To be eligible for an internship an applicant must be a U. S. citizen, a graduate of an accredited seminary approved by the American Association of Theological Schools, an ordained minister in good denominational standing, able to perform the full Protestant ministry within Saint Elizabeths Hospital, and having had a period of satisfactory parish experience. Residencies are open to those who have qualifications listed above but in addition having satisfactorily completed one year of su-

pervised clinical experience in an approved mental hospital training center.

Saint Elizabeths Hospital, an accredited training center, is located in the nation's capital and has long been known for its excellent professional training in the field of mental health and the interdisciplinary approach to treatment, training, and research programs.

Government stipends are given for such training at Saint Elizabeths Hospital at the annual rate of $2800 for Chaplain Interns and $3100 for Chaplain Residents. Quarters on the hospital grounds are available for single students at $10 for a single room and $5 for a shared room. Food may be obtained at the employee's cafeteria.

Inquiries should be made to the Superintendent, Saint Elizabeths Hospital, Washington 20, D. C. Applications for the 1961 program must be received by January 10, 1961.